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Senate

The Senate met at 9:30 a.m. and was called to order by the Honorable NORM COLEMAN, a Senator from the State of Minnesota.

The PRESIDING OFFICER. Today's prayer will be offered by our guest Chaplain, Father Richard S. Dalton, of Christ Our King Mission Church, Rochester, MI.

PRAYER

The guest Chaplain offered the following prayer:

Let us pray.

Mighty God,

We thank You for the gifts You have bestowed on our Nation: the gift of freedom, the gift of plenty, the gift of community, and the countless gifts of beauty You have given this land.

Awaken this land and its people to our accountability before You and our responsibilities to one another. Make us aware of both the gifts and stewardship granted to us, that each person in this Nation will discover their gifts and embrace their callings for our common benefit and to Your glory.

Lord, may Your grace and kindness abide with this Senate, the Senate staffs, and each related family. We pray Your protection and blessing on the mothers, fathers, grandparents, children and all, both young and old, associated with this United States Senate.

May Your care be upon all these gathered and may this Senate body labor during these days as Your ministers for our good.

I pray these things, as Your servant for Jesus' sake.

God may You now bless these Senators, Thy servants.

Amen.

PLEDGE OF ALLEGIANCE

The Honorable NORM COLEMAN led the Pledge of Allegiance, as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

The PRESIDING OFFICER. The clerk will please read a communication to the Senate from the President pro tempore (Mr. STEVENS).

The legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, June 24, 2003.

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable NORM COLEMAN, a Senator from the State of Minnesota, to perform the duties of the Chair.

TED STEVENS,
President pro tempore.

Mr. COLEMAN thereupon assumed the Chair as Acting President pro tempore.

RECOGNITION OF THE MAJORITY LEADER

The ACTING PRESIDENT pro tempore. The majority leader is recognized.

SCHEDULE

Mr. FRIST. Mr. President, the Senate will immediately resume consideration of S. 1, the prescription drug benefits and Medicare bill. There are approximately 33 pending amendments from last week and yesterday. We continue to make good progress. Under the order from last night, we have two consecutive votes this morning at 11 o'clock on the Rockefeller amendment No. 976 and the Bingaman amendment No. 984. Also, last night we reached an agreement to vote at 2:25 this afternoon in relation to the Dodd amendment No. 969 on open enrollments. This morning, the two managers will be working through the pending amendments and will attempt to set up additional votes for this afternoon.

I reiterate once again we will finish this bill this week, possibly Thursday night. It could be a very late Thursday night. I predict it will be a late night tonight, Tuesday night, Wednesday night, and Thursday night. If we spill over to Friday or even Saturday, we will finish this bill before the recess. I do encourage Members to come forward with their amendments as soon as possible and make those available to the managers if you plan on offering those amendments. We have a lot of work to do. The cooperation of Members will be very much appreciated over the next 2, 3 days.

PASSAGE OF S. 1157 AND S. 239

Mr. FRIST. Mr. President, let me just make one final comment. In wrapup last night, we had two very important pieces of legislation pass through the body. We are debating throughout each day the prescription drug benefits and Medicare bill, yet we have other important matters.

Last night, we passed S. 1157, which establishes a National Museum of African American History. Senator BROWNBACK has been working on getting this bill cleared for full Senate action since its introduction on May 23 of this year. I publicly thank him for his efforts and attention on this important issue so that the Senate was able to pass it expeditiously.

Also last night, the Senate passed S. 239, the Trauma Care Systems Planning And Development Act, which I introduced in January of this year. This bill directs the Secretary of Health and Human Services to collect, compile, and disseminate information regarding trauma care and emergency medical services, and, in so doing, takes into special consideration people in rural areas who might not otherwise have access to that care.

I mention those two very important pieces of legislation because I want our

colleagues to be aware we did pass them late last night.

RECOGNITION OF THE ACTING MINORITY LEADER

The ACTING PRESIDENT pro tempore. The assistant Democratic leader is recognized.

Mr. REID. Mr. President, if I could say through the Chair to the leader, as the leader indicated, we have more than 30 amendments. To vote on those would take 12 hours, or something like that. The two managers last night indicated they thought two-thirds of the amendments that are pending could be accepted by the two managers.

We have on our side probably no more than six more amendments to offer on this legislation. Senator BOXER is here to offer her amendment. We have several more that could follow that. Then we have an important amendment that Senators CONRAD and LINCOLN offered. Senator LINCOLN offered it on Friday, but she withdrew it, and she wants to reoffer that today.

I think if we do not have some flareup as a result of someone wanting to change the basic components of the bill, it is very likely we can finish this bill in a reasonably short period of time. I hope the two managers, who were meeting after we adjourned last night, have been able to make headway in working through the money we have left over that has created so much interest. Anytime there are a few dollars—and this is more than a few dollars—left on the table, so to speak, there are a lot of people who are after that money. I hope that can be resolved in some fair manner. But if that is the case, then I think you, the distinguished Republican leader, can complete this bill in a reasonably short period of time.

On our side, we have done our best to have amendments ready to offer. Senator BOXER is in the Chamber. She will not take a great deal of time on her amendment. We have the other key amendments we believe are ready to be offered and can be done in a short period of time.

The ACTING PRESIDENT pro tempore. The majority leader.

Mr. FRIST. I thank the Chair. In brief response, through the Chair, I think it is a very accurate assessment of where we are. The managers continued to meet last night and will continue to meet this morning as we put together the various amendments. So I am very satisfied with the continued progress we are making and appreciate Members on both sides of the aisle coming forward with their amendments. With that, I think we will be able to stay on schedule, giving good, adequate time for debate and amendments.

I yield the floor.

RESERVATION OF LEADER TIME

The ACTING PRESIDENT pro tempore. Under the previous order, the leadership time is reserved.

PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003

The ACTING PRESIDENT pro tempore. Under the previous order, the Senate will resume consideration of S. 1, which the clerk will report.

The legislative clerk read as follows:

A bill (S. 1) to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

Pending:

Graham (FL) amendment No. 956, to provide that an eligible beneficiary is not responsible for paying the applicable percent of the monthly national average premium while the beneficiary is in the coverage gap and to sunset the bill.

Kerry amendment No. 958, to increase the availability of discounted prescription drugs.

Lincoln modified amendment No. 934, to ensure coverage for syringes for the administration of insulin, and necessary medical supplies associated with the administration of insulin.

Lincoln amendment No. 935, to clarify the intent of Congress regarding an exception to the initial residency period for geriatric residency or fellowship programs.

Lincoln amendment No. 959, to establish a demonstration project for direct access to physical therapy services under the Medicare Program.

Baucus (for Jeffords) amendment No. 964, to include coverage for tobacco cessation products.

Baucus (for Jeffords) amendment No. 965, to establish a Council for Technology and Innovation.

Nelson (FL) amendment No. 938, to provide for a study and report on the propagation of concierge care.

Nelson (FL) amendment No. 936, to provide for an extension of the demonstration for ESRD managed care.

Baucus (for Harkin) amendment No. 967, to provide improved payment for certain mammography services.

Baucus (for Harkin) amendment No. 968, to restore reimbursement for total body orthotic management for nonambulatory, severely disabled nursing home residents.

Baucus (for Dodd) amendment No. 969, to permit continuous open enrollment and disenrollment in Medicare Prescription Drug plans and Medicare Advantage plans until 2008.

Baucus (for Dodd) amendment No. 970, to provide 50 percent cost sharing for a beneficiary whose income is at least 160 percent but not more than 250 percent of the poverty line after the beneficiary has reached the initial coverage gap and before the beneficiary has reached the annual out-of-pocket limit.

Baucus (for Cantwell) amendment No. 942, to prohibit an eligible entity offering a Medicare prescription drug plan, a Medicare Advantage organization offering a Medicare Advantage plan, and other health plans from contracting with a pharmacy benefit manager (PBM) unless the PBM satisfies certain requirements.

Rockefeller amendment No. 975, to make all Medicare beneficiaries eligible for Medicare prescription drug coverage.

Rockefeller amendment No. 976, to treat costs for covered drugs as incurred costs without regard to whether the individual or another person, including a State program or other third-party coverage, has paid for such costs.

Akaka amendment No. 980, to expand assistance with coverage for legal immigrants under the Medicaid Program and SCHIP to include citizens of the Freely Associated States.

Akaka amendment No. 979, to ensure that current prescription drug benefits to Medicare-eligible enrollees in the Federal Employees Health Benefits Program will not be diminished.

Pryor amendment No. 981, to provide equal access to competitive global prescription medicine prices for American purchasers.

Bingaman amendment No. 984, to carve out from payments to Medicare+Choice and Medicare Advantage organizations amounts attributable to disproportionate share hospital payments and pay such amounts directly to those disproportionate share hospitals in which their enrollees receive care.

Bingaman amendment No. 972, to provide reimbursement for federally qualified health centers participating in medicare managed care.

Bingaman amendment No. 973, to amend title XVIII of the Social Security Act to provide for the authorization of reimbursement for all Medicare Part B services furnished by certain Indian hospitals and clinics.

Baucus (for Edwards) amendment No. 985, to strengthen protections for consumers against misleading direct-to-consumer drug advertising.

Baucus (for Lautenberg) amendment No. 986, to make prescription drug coverage available beginning on July 1, 2004.

Murray amendment No. 990, to make improvements in the Medicare Advantage benchmark determinations.

Harkin amendment No. 991, to establish a demonstration project under the Medicaid Program to encourage the provision of community-based services to individuals with disabilities.

Dayton amendment No. 957, to provide that prescription drug benefits for any Member of Congress who is enrolled in a health benefits plan under chapter 89 of title 5, United States Code, may not exceed the level of prescription drug benefits passed in the 1st session of the 108th Congress.

Dayton amendment No. 960, to require a streamlining of the Medicare regulations.

Dayton amendment No. 977, to require that benefits be made available under Part D on January 1, 2004.

Baucus (for Stabenow) amendment No. 992, to clarify that the Medicaid statute does not prohibit a State from entering into drug rebate agreements in order to make outpatient prescription drugs accessible and affordable for residents of the State who are not otherwise eligible for medical assistance under the Medicaid Program.

Baucus (for Dorgan) amendment No. 993, to amend title XVIII of the Social Security Act to provide for coverage of cardiovascular screening tests under the Medicare Program.

Grassley amendment No. 974, to enhance competition for prescription drugs by increasing the ability of the Department of Justice and Federal Trade Commission to enforce existing antitrust laws regarding brand name drugs and generic drugs.

Durbin amendment No. 994, to deliver a meaningful benefit and lower prescription drug prices.

The ACTING PRESIDENT pro tempore. The Senator from California.

Mrs. BOXER. Mr. President, I ask unanimous consent the pending amendments be set aside.

The ACTING PRESIDENT pro tempore. Is there objection?

Hearing none, it is so ordered.

AMENDMENT NO. 1001

Mrs. BOXER. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The ACTING PRESIDENT pro tempore. The clerk will report.

The legislative clerk read as follows:

The Senator from California [Mrs. BOXER], for herself and Ms. MIKULSKI, proposes an amendment numbered 1001.

Mrs. BOXER. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To eliminate the coverage gap)

On page 49, strike line 3 through page 50, line 2 and insert the following:

''(2) LIMITS ON COST-SHARING.—

''(A) IN GENERAL.—The coverage has cost-sharing (for costs above the annual deductible specified in paragraph (1) and up to the annual out-of-pocket limit under paragraph (4)) that is equal to 50 percent or that is actuarially consistent (using processes established under subsection (f)) with an average expected payment of 50 percent of such costs.

''(B) APPLICATION.—Notwithstanding the succeeding provisions of this part, the Administrator shall not apply subsection (d)(1)(C) and paragraphs (1)(D), (2)(D), and (3)(A)(iv) of section 1860D–19(a).

Mrs. BOXER. Mr. President, I offer this amendment in the true spirit of making this bill work, making it a bill that isn't confusing for our seniors, a bill that doesn't cause a hardship, as the existing bill does, for those who are the sickest.

In this amendment I have the support not only of several colleagues but of the AARP, which very strongly supports it. As you know, they have been choosing their amendments very carefully. Also we are supported by the National Committee to Preserve Social Security and Medicare. So we have both the largest senior citizen organizations backing this amendment.

I was proud to give the national Democratic radio address on Saturday. I did it on this particular issue. The issue I will be addressing through this amendment is ending the benefit shutdown that occurs in this bill just at a point in time when seniors need their benefit the most. I will explain it because it isn't that complicated once you explain it.

Let me take a step back and say the best thing about the bill before us is it starts a Medicare benefit prescription drug benefit for our seniors. We have been talking about this for years. We have been pushing it for years. Since Medicare was created 38 years ago, seniors have been waiting for a prescription drug benefit. I must say, the older I get the more I realize the revolution we have seen in medicine, one that is now one of prevention. If one takes a high blood pressure medicine, if one can't control it any other way, it becomes absolutely a lifesaving benefit. If one doesn't do that or one can't afford to do that, the chances of stroke or heart disease go up immeasurably. So the best thing about the bill before us is that it begins something so many of us have fought for so long.

Unfortunately, the plan is wanting. The plan needs to be improved. It is very complicated. I have read this from a Senator on the Republican side. I heard from a Senator on the Democratic side:

No one really understands this.

That was a reference to Senators. I have a handle on what this bill does. I have had to work; I have had my staff work. I am fortunate to have a good staff. I have talked to my colleagues. But if it took me so long to figure this out, what will it do to our people.

One of the improvements we should make is this amendment I offer. I want to explain exactly what I mean when I say a benefit shutdown. It has been called a number of things—a coverage gap, a donut hole. But a benefit shutdown really explains it because here is what happens. You are going about your business. You are paying your premium. You are getting your 50-percent benefit after you pay your deductible. And bingo, you hit a certain point and what happens? No more benefit.

I have studied 100 different plans that offer a benefit. Ninety-nine of them don't have any of this. One of them has this, but it is a very rich plan and the benefit shutdown is very small. So this is the only plan I have ever seen in existence that has this ridiculous benefit shutdown. I don't understand why it happened, but I guess the bill was a compromise so that is why we have it.

Let me explain what it means. I will show a couple of charts to you. After a senior pays $275 in a deductible, they start getting 50 percent of the cost of the drug reimbursed. So it is a 50-percent benefit, once you have paid your deductible. By the way, every month you have at least a $35 premium.

Now all of a sudden, you get to $4,500 worth of drugs and your benefit shuts down and the next $1,300 you have to pay out of your own pocket. I know the State of the Presiding Officer is not much different from mine in the sense that our seniors are mostly low income. Many of them are living on their Social Security checks, maybe a little more, but since the market went down, many of them are relying on their Social Security checks. For them to have to pay $1,300 right in the middle of a year is absolutely outrageous. That is why AARP is supporting my amendment. They sent out a letter on my amendment.

I ask unanimous consent to print the letter in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

AMERICAN ASSOCIATION
OF RETIRED PERSONS,
Washington, DC, June 19, 2003.

Hon. BARBARA BOXER,
U.S. Senate,
Washington, DC.

DEAR SENATOR BOXER: AARP supports your amendment to close the coverage gap that exists in the drug benefit design of S. 1.

Throughout the debate over a Medicare prescription drug benefit, AARP has voiced our members' concerns about the need for affordable and adequate coverage. Chief among these concerns continues to be the existence of a gap in the benefit. We appreciate the efforts made by the Finance Committee to close the gap and we believe the Senate should finish the job.

AARP members find the notion of a gap in coverage to be a major barrier to enrolling in a Medicare drug benefit. They tell us that they are unaware of similar features in any of the insurance products they routinely purchase. Our members do not understand why coverage would cease at a time when their drug expenses increase. The continued existence of this benefit gap threatens the workability of the benefit by jeopardizing adequate enrollment, and thus the program's ability to spread risk. Therefore, we urge the Senate to eliminate this coverage gap.

Thank you for your leadership on the issue. We look forward to working with you and other members of the Senate to enact a prescription drug benefit that will provide meaningful relief to current and future Medicare beneficiaries.

Sincerely,

WILLIAM D. NOVELLI.

Mrs. BOXER. I will read it. That is why they said I could mention on the national radio address that they support my amendment—a $1,300 cost after you hit $4,500.

Let's take the case of someone who has $7,000 a year in drug costs—and many people do. Their estimated annual premium? At least $420, maybe a little more. Their deductible? $275. They pay 50 percent of the cost of their medication, $2,113, until they get to $4,500. Now comes the benefit shutdown where they have to pay 100 percent of the cost between $4,500 and $5,812. It is actually $1,312. Then they get a good catastrophic benefit where they pay 10 percent. Look at what the senior is paying for this benefit: $4,239 out of a $7,000 bill.

The point is, because of this benefit shutdown and the huge penalty, a lot of our senior citizens would get a better drug benefit if they went to Canada and bought their drugs. This is a fact. They would be better off if they went to Canada and bought their drugs. But we can fix it today. We can end this benefit shutdown, and then the benefit will be far better.

Another way to look at the benefit shutdown is to see how unfair it is to our beneficiaries. You are paying your monthly premium every single month; $35 is what we are suggesting. But it could go up. We haven't reined in what they could charge you. Anyone who has dealt with insurance companies and HMOs knows that costs go up. Even Medicare has had to raise its costs a little bit. But by the way, because Medicare administrative costs are so low, at 3 percent, compared to these companies which could be as high as 25 percent, Medicare keeps the costs down. But under this bill, you only get Medicare if you can't get a private company. So I am telling you, we are going to have seniors maybe facing increases in their premiums. But let's give it a shot. Let's say it is only $35. It is $35 a month every single month. And guess what happens in October, if you have this kind of $500-a-month expense—just to use that as an example—you do not get that benefit for almost 3 months out of the year.

What kind of plan is this? Fortunately, it is voluntary so people have to think long and hard if it makes sense for them to do it. And I will give credit where credit is due. For our lowest income people, it may be a decent deal. But for your average recipient, to have to explain why they get no benefit for 3 months puts us in a terrible situation. It harkens back to the days when we did a catastrophic benefit and seniors took it. Then when they realized what it was, they were so angry, they were just throwing themselves on legislators' automobiles to protest. I am not kidding. This happened.

I don't want to see that happen. I want to see us do a good bill, one that is really straightforward, not confusing. So we have a real problem for our vulnerable citizens.

The last chart I am going to show is this chart because I said I would read to you from AARP's letter that they sent me. I hope colleagues will listen to what they say:

AARP members find the notion of a gap in coverage to be a major barrier to enrolling in a Medicare drug benefit. They tell us that they are unaware of similar features in any of the insurance products they routinely purchase. Our members do not understand why coverage would cease at a time when their drug expenses increase. The continued existence of this benefit gap threatens the workability of the benefit by jeopardizing adequate enrollment, and thus the program's ability to spread risk. Therefore, we urge the Senate to eliminate this coverage gap.

Mr. President, that is exactly what my amendment does. Let me go through this one argument at a time.

AARP members find the notion of a gap in coverage to be a major barrier to enrolling in a Medicare drug benefit.

Well, clearly, Mr. Novelli and the AARP understand the fact that you have a barrier when you know that perhaps for 3 months, even though you are paying your premium, you get no benefit. Again, we have studied all the plans. Virtually no plan in America has a benefit shutdown. So let's make this bill better.

Let's see the next thing AARP says:

They tell us that they are unaware of similar features in any of the insurance products they routinely purchase.

Absolutely. Only in the Congress could somebody come up with this way to save money. It is ridiculous. You are penalized if you are really sick. You are penalized if you are really sick because if someone gets cancer and has to buy very expensive drugs, or a family member gets Alzheimer's and they are trying to treat the disease in a way so they can have their loved one around longer, that is when they get hit with a benefit shutdown. How unfair is that?

Our members do not understand why coverage would cease at a time when their drug expenses increase. The continued existence of this benefit gap threatens the workability of the benefit by jeopardizing adequate enrollment, and thus the program's ability to spread risk.

What does that mean? It means that as seniors learn what this program is about, they may well come to the conclusion, depending on the size of their drug bill, that they are better off making a trip to Canada. They will save more than going through all the rigmarole—Senator CLINTON showed on a chart the rigmarole you have to be involved in, and because the way the bill has tried to really privatize this benefit, you are at the risk of the marketplace. The risk of the marketplace is OK when you are buying a car; it is OK if you are buying a dishwasher. You are at the risk of the marketplace. Yes, if it was a year when people held back and didn't produce a new product, OK, you are disadvantaged; OK, that is the risk. But to put seniors at the risk of the marketplace for drugs is a very bad idea indeed.

Therefore, we urge the Senate to eliminate this coverage gap.

This letter is signed by William Novelli, executive director and CEO of AARP. It is a nonpartisan organization that supports this amendment strongly. We want to close this gap. We want to stop this benefit shutdown. Again, a very graphic way to show what happens to you is to say that seniors will pay half of their annual drug cost from $276 to $4,500—that is their 50 percent benefit—and then they face a $1,300 benefit shutdown, just at the time they need their medicine the most. It makes no sense.

You know, $1,300 may not sound like a lot to some of our Senators here. We get good pay and, by the way, we have a pharmaceutical benefit in our health plan. It is a very good one. It is an excellent one. You know what. It doesn't stop when you hit a certain level. Our pharmaceutical benefit just keeps on going. It just keeps on coming, as do pharmaceutical benefits in practically all the plans in America today.

Just think about the administrative overhead to figure this one out. You are going along and, all of a sudden, this red arrow kicks in: Stop. I want to know how much it is costing us to administer this kind of deal. You can imagine, you get a note in the mail. Your benefit stops. You have paid $4,500. You go back and check your records. No, I didn't, I have only paid $4,200. You call up the administrator: You have made a mistake. Well, no, I didn't. Well, yes, you did.

How many hours will a senior who is confused and upset have to spend on the phone? How many hours will an administrator have to spend working on the details of this? Too long, I can tell you that.

This plan, as it is before us, if this amendment doesn't pass, pulls the rug out from underneath the people who are going to need the help the most. So if we are in this in order to offer a plan that people will utilize, then let's support this amendment. It is as simple as that.

Many seniors take medicines to manage chronic health problems. I discussed that at the beginning. How wonderful is it that today we can avoid horrible outcomes by taking pills that will help keep our blood pressure down, regulate our heart rate, keep our insulin in check—I could go on and on and on. Some of our seniors are cutting their pills in half because they cannot afford it. How tragic would it be if, after they think they are going to have this great benefit, they find out they could do better going up to Canada and buying the pills because maybe it comes out to 25 percent when all is said and done, when you put in the benefit shutdown, the premiums cost, and the deductible. It just may not add up. How sad it would be if, after all the hoopla we are associating with this bill, the bill itself is inadequate.

I received a letter from a constituent in San Marcos, CA. She has an annual prescription drug cost that will top $10,000. Well, she will be hit with this benefit shutdown.

Another constituent from Indio, CA, told me she has made five trips to Mexico over the last several years to purchase her prescriptions. This senior drives all day long to Mexico in order to purchase affordable heart medicine that she needs to survive, that she needs so that she can wake up every day and see her grandchildren, and take a walk, and have a quality of life. She is awaiting a benefit that will make it easy for her to go down to her corner pharmacy and say: Here is my card; I am ready to go. But this particular senior is going to be shocked to find out that if she is in the category of the benefit shutdown, it is going to cost her $1,300, plus at least $35 a month, plus a deductible.

A retired physician from Marina del Rey told me that a pill he takes for heart disease went up 600 percent—from $15 to $85. So for seniors who have to take an assortment of medicine to manage chronic diseases, the cost really starts to add up.

I have 4 million senior citizens who are part of the Medicare Program in my State. If you take the population of Delaware, that is five Delawares. That is how many senior citizens I have, and they deserve a break.

Unfortunately, this bill gives them a break, a break in coverage. Let's close that break in coverage. Let's close that gap, stop the benefit shutdown, and let's have a bill of which we all can be proud.

Again, this benefit shutdown is unheard of if we look at all the plans. It would not happen to you, Mr. President, if you have FEHBP. It will not happen to your wife, your kids, or you. It does not happen to me. I do not walk in and they say: Oh, Senator, sorry, you are in that time of the year; gee, just for these 3 months, you do not get any benefit at all. I guarantee you, if our plan did that, there would be shouting at the caucus lunches: What kind of plan do we have that we walk in, in the middle of the year, and somebody tells us we do not have coverage? We are paying our premium.

We would not stand for it.

Why are we giving a plan to the seniors we represent that is far worse than the plan we have? Because we want to give tax breaks for the wealthy few, and so we cannot afford to do this?

This is not a costly fix. CBO is telling us it is $60 billion out of a $400 billion bill. Let's figure out a way to pay for it. It is easy. I can tell you right now the administrative costs in this bill range from 15 percent to 25 percent. That is $100 billion. Why are the administrative costs so high? The private sector is doing it, not Medicare. Medicare has a 3-percent overhead. The private sector has a 10- to 20-percent overhead. Let's take the bill back and figure it out and close this benefit shutdown.

I do not want to be the Senator who stands up and votes for this with a smile on my face and then have a senior stand up and say: Senator, I walked into my pharmacy in October. I have $500-a-month drug expenses, and guess what, I have no benefit. I had to pay $1,300 out of my own pocket just when I needed the drugs the most. Why are you doing this to me? Why don't you do it to yourself?

That is what I hope they say.

I am so happy we are discussing a Medicare drug benefit, believe me. I share the views of a lot of my colleagues that it is time we have one, but to have this plan, the only plan in the country virtually that has a benefit shutdown, is an embarrassment to me. We do not have it in the Senate plan. They do not have it over in the House, I assure you of that.

We should not have a benefit that starts and stops. What is really frosting Senator GRAHAM is that seniors even have to pay a premium during this benefit shutdown. So he has an amendment—we have not voted on it yet—that says at least for October, November, and December, do not charge seniors a premium.

It is the same as if someone walked in a store and said: I want to buy a TV set, here is my money; I am going to pay it off over 3 months, here is my money. And they say, thank you very much; you are not getting a TV set; we will deliver it in 3 months. But you advertised it. No, you have to pay me 3 months, and then I will send you your TV set.

In a free market economy, this is a very sick idea. This does not make any sense. In our society, if you put money down, you pay for a benefit, you pay for a product, you get it.

I think BOB GRAHAM has a good idea: If you are going to do this to seniors, then do not make them pay their premium. At least show some regard for the person.

You are a senior; you are on several drugs; you are feeling good; the medicine really helps you; you have signed up for the plan; you have paid your deductible; you start getting your 50 percent benefit; and, boom, it is over, when you reach $4,500. Your benefit shuts down.

I cannot say it enough. It is unheard of to pay a $1,300 penalty for sickness. I cannot say it enough.

You have signed up. A few months go by, and you add the costs up in your head trying to figure out how much your medicine is costing. You realize you are going to hit the $4,500 benefit shutdown. Your doctor says you need to keep taking the medicine because you are worse, and he knows you are worried about entering the benefit shutdown. You are going to be hit with the full cost of those drugs for that period. What are you going to do?

You sit down and you crunch the numbers. You ask: How can I cut costs? You may well skip your medicine; you may well cut the pills in half; and you may well threaten your health and your life.

The benefit shutdown is wrong. It goes against everything we do in this country. Nobody else does this. It is not that expensive to fix. You are going to need a calculator every time you try to figure out what you have to save. You are going to need a good accountant.

A shutdown is going to cause trouble with the administration of this benefit. People will be calculating: Gee, Mr. THOMAS has used $3,925. Let's get him on the watchlist. Mrs. BOXER over there, she has used $4,000. Then suddenly you are cut off. You call up and you do not understand it. It is going to take hours to explain it to a senior citizen.

In closing my discussion of this amendment—and I will be asking for the yeas and nays on this amendment—the National Committee to Preserve Social Security and Medicare and the AARP, the two biggest senior citizen organizations in this country, endorse this amendment.

I am to again read from Mr. Novelli's letter because this says it all in a very clear way, and I hope my presentation has demonstrated that everything Mr. Novelli, the CEO of AARP, has stated is true:

> AARP members find the notion of a gap in coverage—

That is benefit shutdown—

> to be a major barrier to enrolling in a Medicare drug benefit. They tell us that they are unaware of similar features in any of the insurance products they routinely purchase. Our members do not understand why coverage would cease at a time when their drug expenses increase. The continued existence of this benefit gap threatens the workability of the benefit by jeopardizing adequate enrollment and thus the program's ability to spread risk. Therefore, we urge the Senate to eliminate this coverage gap.

Signed William Novelli, AARP.

I thank the AARP because I know they are calling colleagues and explaining this. Just remember, do unto others as you would like them to do unto you. Do my colleagues want to have their drug benefit changed so that just when they need their pharmaceutical product the most, they tell you it is not covered for you; it is not covered for your wife; it is not covered for your husband; it is not covered for your children? Mr. President, you do not want that. Why are we doing it to the seniors? At least give them a break and close down this benefit shutdown because if we do not, if we do not vote for this amendment, people are going to be at our doors because they are not going to understand it.

If my colleagues vote for this amendment and we fix this, we can truly say we have made this a far better plan, a plan more like our own, a plan more like the other 100 plans I have looked at.

I yield the floor.

I ask for the yeas and nays on the amendment.

The PRESIDING OFFICER (Mr. GRAHAM of South Carolina). Is there a sufficient second? At this time, there is not a sufficient second.

Mrs. BOXER. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mrs. BOXER. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mrs. BOXER. I renew my request for the yeas and nays on the amendment.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I ask that all pending amendments be temporarily laid aside so the Senator from Arkansas can offer an amendment.

The PRESIDING OFFICER. Without objection, it is so ordered. The Senator from Arkansas.

Mrs. LINCOLN. I thank the ranking member of the Finance Committee, as well as the chairman, for their diligence in this very important issue.

I say to my colleagues, I do not think we will be taking up an issue quite as critical as this one for quite some time when we reflect both on the economy of our country and the quality of life we want to provide our seniors in this Nation and, more importantly, when we think about where our Nation is going in terms of the demographics and the number of seniors we actually have in this country, going from 41 million Americans over the age of 65 to an explosion in the next 15 to 20 years of almost 70 to 75 million Americans over the age of 65.

In looking at this prescription drug package, I hope we all will look at it not only as an ability to provide the seniors the kind of quality of life we want to provide them but that we also look at it as an economic issue in terms of what it is going to cost us in this great country to provide the kind of quality of care in the next 20 years if we do not look at a prescription drug

package which is going to provide our seniors with the ability to live their lives in a way where it will be less costly to the more expensive areas of health care and, more importantly, they will be able to live the final years of their life in comfort and certainly more comfortable circumstances, hopefully at home, and have the quality of life we want them to have.

Medicare has been a successful, stable program for millions of seniors and individuals with disabilities for over 40 years. Medicare has succeeded in guaranteeing hospital coverage and physician coverage for a population which was largely uninsurable. Now we are debating adding prescription drug coverage to the Medicare Program and we should do it in a way that echoes that same stability in the program seniors enjoy.

AMENDMENT NO. 1002

Mrs. LINCOLN. Mr. President, at this time I send an amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Arkansas [Mrs. LINCOLN], for herself, Mr. CONRAD, Mr. MILLER, and Mr. CARPER proposes an amendment numbered 1002.

Mrs. LINCOLN. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To allow medicare beneficiaries who are enrolled in fallback plans to remain in such plans for two years by requiring the same contracting cycle for fallback plans as Medicare Prescription Drug plans)

On page 83, strike lines 1 through 7, and insert the following:

''(5) CONTRACT TO BE AVAILABLE IN DESIGNATED AREA FOR 2 YEARS.—Notwithstanding paragraph (1), if the Administrator enters into a contract with an entity with respect to an area designated under subparagraph (B) of such paragraph for a year, the following rules shall apply:

''(A) The contract shall be for a 2-year period.

''(B) The Secretary is not required to make the determination under paragraph (1)(A) with respect to the second year of the contract for the area.

''(C) During the second year of the contract, an eligible beneficiary residing in the area may continue to receive standard prescription drug coverage (including access to negotiated prices for such beneficiaries pursuant to section 1860D–6(e)) under such contract or through any Medicare Prescription Drug plan that is available in the area.

At the end of title VI, add the following:

SEC. ___. MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking ''promptly (as determined in accordance with regulations)'';

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

''(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

(b) CLARIFYING AMENDMENTS TO CONDITIONAL PAYMENT PROVISIONS.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: ''An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.'';

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: ''A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.''; and

(B) in the final sentence, by striking ''on the date such notice or other information is received'' and inserting ''on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received''; and

(3) in subparagraph (B)(iii), , as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: ''In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.''.

(c) CLERICAL AMENDMENTS.—Section 1862(b)(42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking ''such'' before ''paragraphs''.

Mrs. LINCOLN. I am extremely proud to offer this amendment with my colleagues, Senators CONRAD and MILLER. Our amendment seeks to make the drug benefit more predictable and reliable for seniors by allowing them to remain for 2 years instead of 1 year in what we are calling the fallback plan that is outlined in S. 1. As I mentioned when I began speaking this morning, Medicare is here because over 40 years ago more than a majority of seniors in this Nation were uninsurable. We were finding that private industry was not finding this group of individuals profitable enough to actually be in the marketplace and provide them a plan. So I think it is critical, as we look at what we are trying to do today in reforming Medicare and providing a prescription drug plan, that we look at what history has shown us and that we are careful to make sure the plan we provide is going to meet the needs as well as to be fair for all seniors in this great Nation and across the demographics of our country.

Senator CONRAD and I raised this issue in the Finance Committee several weeks ago, since our States are primarily rural and have not historically been attractive to the private insurance industry. This amendment we are offering today simply requires the same 2-year contracting cycle for fallback plans as is required for the private drug-only insurance plan.

We want to make sure the private plans that can come in for a 2-year contract for our seniors who are out in rural areas, who are disproportionately low income, who are less attractive in many ways for these private entities to serve, will have the same opportunity and the same stability other regions of the Nation will have because those fallback plans will be there for the same amount of time as the private insurance industry.

In the underlying bill, Senators GRASSLEY and BAUCUS took a number of steps to encourage private drug-only insurance plans to contract with Medicare and deliver the drug benefit. They created a special transition risk corridor in the first 2 years to encourage these plans to participate, and they gave the administrator of CMS additional tools to get the plans in there. If the administrator determines that at least two plans cannot stomach accepting the minimum requirements for accepting risks described in the bill, then the administrator can reduce the amount of risk plans needed to assume. Alternatively, the administrator can increase the reinsurance percentage or the subsidies to encourage drug-only insurance plans to participate.

By doing all of these things, this bill acknowledges these plans currently do not exist in nature, as has been the statement of our current CMS administrator, and they must be enticed to come in and do the job. In other words, we have basically bent over backwards in this bill to bring private plans into this arena of Medicare prescription

drugs, particularly in areas where they traditionally have not come.

However, there is still no guarantee they will. That is why I am glad Senator GRASSLEY and Senator BAUCUS created a Medicare-guaranteed drug plan, or safety net, called the fallback. If the administrator exhausts all his options and still no two plans want to come in and deliver drugs to our elderly, then a Medicare-guaranteed plan or a fallback plan will deliver that drug benefit.

The only problem I have with the fallback is it is available for seniors for only 1 year at a time. This means if private insurers decide to test whether they want to offer the benefit in a community, seniors lose access to the fallback plan even if the new plan is significantly more expensive for them and/or more restrictive.

What does this mean in real life? Imagine this scenario in this chart. We have it on a chart so it certainly makes a lot of sense. There is an 85-year-old senior in rural Arkansas who enrolls in a fallback plan, fallback No. 1, in 2006 because there is only one private drug-only plan that is available in that area. Then in 2007, another private drug-only plan B enters the region so she must leave the fallback and enroll in one of them even if the new plans are not better for her.

She chooses private plan A. She suddenly has a different premium, a different cost sharing, a different formulary, and a different set of preferred network pharmacists. She must figure out if her drugs are going to be covered or not and where they must go to get them.

Then the next year, in 2008, private plan A leaves so she must again leave her plan. She enrolls then in plan B and gets used to the new premium, the new formulary. But then plan B departs in 2009. With no plans in the area, she enrolls in a new fallback plan with a whole new premium, a whole new formulary and pharmacy network, and it could go on and on.

I don't usually use charts, but I feel very comfortable with this chart because we have seen this happen before. We have seen it in rural areas where Medicare+Choice has come in, they have enticed our seniors, and then they have left very quickly, leaving seniors without any kind of coverage, having to go back to the traditional Medicare product. We know it can exist because we have seen it before.

What we want to do is to simply give seniors, particularly in rural areas, more stability in what we are proposing in this Medicare prescription drug plan. This is certainly a very real circumstance that could happen as the seniors move in and out—the fact that even in the fallback plans there is no standard design, so even when a fallback plan leaves and comes back 2 years later, it will still be a whole new scenario.

Both in the caring for my aging parent and my husband's aging parents, as well as my husband's grandmother who will be 106 this year—which is amazing in itself—providing them with more confusion is not where we want to go. We want to make this as simple as possible. We want to make it as easy a transition as we possibly can. Their management of multiple diseases or chronic problems is heavy enough in terms of the weight on their shoulders and their emotion. Providing them every year with the unfortunate circumstances of having to find a new formulary, find a new premium, a new pharmacist provider is absolutely not what we are trying to do.

I plead with my colleagues, I don't want to be in such a horrible position as this. I don't want to force my constituents in it either. It would be confusing to me. All we are asking of our colleagues is to give the fallback plan the same opportunity to succeed as we are giving those private plans, to make sure it will be there in a way that seniors will have some stability.

I hope our amendment can be adopted. It simply requires that 2-year contract, putting it in line with the current private sector business practices that happen in the real world. After all, that is what we are trying to do, make sure we provide a plan that is common in the real world. We use the analogies of plans that already exist—the FEHBP plan that we have as Federal employees. We look at what already exists in a traditional Medicare plan now. We want to make sure we provide as much continuity for our seniors as we possibly can.

This amendment goes a long way to ensure more consistency and stability for our seniors. This amendment improves seniors' choices by providing them the option not to bounce back and forth between plans with different benefits and premiums. It improves fairness by allowing seniors in both drug-only and fallback plans to remain in those plans for the same 2-year timeframe. It improves the stability of the benefit package by reducing the year-to-year variability in premiums, in cost sharing, in formularies, in local pharmacists.

I don't know how many questions other Members get from their seniors, but I get a ton of them. In my State offices, seniors call all the time for help with benefits and concerns about things that are not covered currently under Medicare. If you have not got it already, you can well imagine what the barrage on your staff and your offices is going to be when these seniors find themselves, particularly in rural areas, where they are flip-flopping back and forth from one plan to another every year without an understanding of what that plan actually is going to provide.

This amendment also aligns contract cycle with current business practices. The PBMs serving the private sector typically have 3- to 5-year contracts. Requiring the fallback plans to have a 2-year contract better reflects the real-world practices and increases the guarantee they will bid to serve regions where drug-only plans have failed to come. It also continues to allow seniors to enroll in drug-only plans even if a fallback plan is available for 2 years. Nothing prevents a senior from enrolling in a private drug-only plan if one is available in the region.

That goes back to one of the best arguments for this plan. That is, if the private plans are there and are working, you do not have to worry; the fallback plan is not even going to be there to begin with. It is not even going to exist if there are two competing private drug-only plans in the region. This is completely hypothetical if, in fact, the underlying premise that the private drug-only plans are going to reach out to every region of the country and they will be there offering a good benefit to all of our seniors.

The problem is we have history. We know it traditionally has not worked in our rural areas. We want to make sure our seniors get the same consideration other seniors in this great country get. It continues to give drug-only plans first bidding rights. Fallback plans only come to the regions after the CMS administrator has determined that two private drug-only plans will not be available, after he has exhausted all of these tools, of which we have given him many in order to entice these plans in there.

It has a very minimal scoring impact. This amendment buys a lot in making the system more stable but costs almost nothing. It is very reasonable in cost, and we pay for it, so there is no problem in terms of what we are talking about doing.

I am very proud to have worked on this amendment with my colleague, Senator CONRAD, who will speak about the importance of the amendment in making the drug benefit more predictable and reliable for seniors. I am pleased Senator MILLER has joined. Many other Senators I have visited are anxious to know about the policy we begin in this drug package for Medicare seniors, that we absolutely enter into what we are doing with the knowledge that legislation we work on here we understand is not a work of art, it is a work in progress; as we move through these processes to improve legislation, that we will take the time to understand small details. If we can supply the fallback the same opportunity, then we can also make sure this bill is going to be good for everybody.

We know as we move through the debate on this bill, as we move through the implementation, there will be multiple changes that will occur. It is important, as we take the time as we initially debate this issue, that we recognize all parts of our Nation are not exactly alike, that a one-size-fits-all is not going to fit every region of this Nation.

Most importantly, every senior in this great country is just as important as the other. If you are a low-income senior living in a rural part of this Nation and have worked hard your entire

life and want to retire in the same area in which you grew up and where you raised your children, you are not going to be slighted in a prescription drug package simply because of where you live or the fact you worked at a lower income job and may not have as much to retire on as other seniors across this Nation.

I hope as we move forward in this amendment and in this bill, we will recognize there are places where we can improve it. We will lead the charge, knowing that is what our job is, that is what this great deliberative body is for. It is to make the improvements along the way and to push a bill forward that, in the long term, will provide a better benefit for people across this Nation. But, most importantly, we must recognize our Nation is diverse. That is a huge part of its strength. Those of us who come from rural areas recognize that sometimes our needs are met in different ways.

I encourage my colleagues to take a look at this very simple amendment that doesn't cost much but can make up a great deal of ground in this bill in bringing parity for all seniors across this Nation.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, I see my friend from North Dakota is eager to address the Senate. I will just be a few minutes on this particular amendment.

AMENDMENT NO. 1001

Mr. President, I rise to commend the Senator from California, Senator BOXER, for her amendment. I will support this amendment for the very sound reasons she has outlined here on the floor of the Senate.

Just going back very quickly, in 1965 we passed Medicare and we said to our seniors: Pay into the fund, play by the rules, and your health benefits will be attended to. Therefore, we provided the hospitalization and the physician fees. At that time, only 3 percent of all private companies provided any kind of prescription drug protection.

We have made extraordinary progress in recent years with the development of prescription drugs to tend the needs of all of our citizens and particularly the elderly. Now prescription drugs are as important as hospitalization and physician fees.

What this overall debate has generally been about, in terms of the prescription drug program, is how and when are we going to pass a prescription drug program that will be worthy of our senior citizens and do for our senior citizens what the hospitalization program and the physician programs, which are under Medicare, Part A and Part B, do for our seniors.

This particular proposal we have before the Senate now has two very important gaps. The Senator from California has pointed out one very important gap, a failure to provide services to many of our elderly. There is a second important gap and that is how we treat our retirees.

Senator BOXER has outlined the benefit gap that exists under this proposal. What we are talking about is seniors are going to be spending $1.8 trillion over the next 10 years. This bill only provides for $400 billion. It is only really about 22 percent of all that is going to be necessary for our seniors over the period of the next 10 years.

The issue before us is, first, whether seniors will be able to get the prescription drug program through their Medicare program. I believe the way this bill is constructed they will be. Second, what will the amount available to them be. Clearly, this bill is short.

What the Senator is reminding us about, with her excellent presentation, is that if the Senate itself had the will we could be providing the complete amount necessary to meet all the needs of our senior citizens. I believe that is what we should do.

We have had this debate before in the Senate under the Graham-Miller proposal last year, which I was proud to support. That would have cost close to $600 billion over a period of 8 years. The House Democrats had a different proposal that would have been, actually, close to $1 trillion. But it would have made all the difference and would have attended to the needs of our elderly people.

The Senate has made a different judgment. They have decided they were going to provide $3 trillion in tax cuts for the wealthiest individuals, and give short shrift to our seniors with a $400 billion proposal. That is what we have here in the Senate.

We have had opportunities, even while we were debating the tax proposal. A number of us offered amendments and said let's just take the reduction in the top three rates and perhaps the dividend tax reduction and, instead of going ahead with those additional deductions, use those resources and put them onto a prescription drug program.

We got 49 votes here in the Senate. We got 49 votes here. This body is evenly divided, effectively, on the concept that the Senator from California has provided. Virtually half of this Senate wants to provide the full benefits which would be included in the Boxer amendment. That is what I think needs to be done if we are going to provide a meaningful benefit to seniors.

As this chart points out and as the Senator has explained, after paying the $275 dollar deductible, for expenditures up to $4,500, we are finding 50 percent of all the expenditures effectively are paid for. Then we have the benefit gap in here, which is sometimes known as the donut hole. And then we find the expenditures for our seniors up at 90 percent in the high-cost areas.

It is this area the Senator from California is addressing. I imagine she would like, as well, to try to do something about reducing this deductible or even the premiums as well. Her amendment certainly would do that.

We are back to the real choice of what is important. Are we as a Nation going to say it is more important to have a prescription drug program worthy of its name and support the Boxer amendment? Or, are we going to fail to do that? I, as one Senator, as long as I am in the Senate, am going to continue to fight to be sure we provide the resources to do for prescription drugs what we are doing for our seniors under hospitalization and also with physician fees. I think that is what is fair. That is what is necessary. That is what we mean when we talk about having a good prescription drug program. That is what is really called for if we are going to be true to our senior citizens.

I thank the Senator for raising this issue again. It is really a question of choices. It is a question of priorities. This Senate has made a judgment, a decision previously that what we ought to do is provide tax reductions of $3 trillion, and therefore there are those who say we cannot afford to do what we should be doing for the senior citizens of this country. I regret it. It does seem to me the amendment, which says let's go ahead and pass the Boxer amendment and then we will sort through the pressures we are going to have on our budget in the future and perhaps review some of those excessive tax reductions—it seems to me that is in the Nation's interest.

This is a question of priorities. It is a question of choice. It is a question of value. The Senator from California has made what I think is a compelling case about what is needed to do the job. Mr. President, 22 percent is what this downpayment is. I consider it a downpayment. As I mentioned on all occasions, I think the downpayment is out there. I am going to do everything I can—I am sure the Senator from California is as well—to make sure there is not just a downpayment, but there is going to be a continuing effort on our part to make sure the senior citizens are going to be treated fairly.

Mrs. BOXER. Will my friend yield?

Mr. KENNEDY. I am happy to yield.

Mrs. BOXER. I want to ask a couple questions. The Senator used the term ''donut hole.'' I used the phrase ''benefit shutdown.'' It's all the same. But on the chart, between the yellow and the red, is a big white space. That means that between $4,500 and $5,800 essentially there is no benefit. This is a cost.

My friend is right. All we had to do is tighten up a little bit on what our colleagues wanted to do for the people who earn $1 million a year. It would not have taken that much. The cost of this, after the $400 billion, is $60 billion. We got that from CBO, a $60 billion cost.

My question is basically this: Does he not believe, when you really take a look at this, the administrative costs of making this work are going to be quite large? Think about the accounting that has to go into it, to track everybody's benefit. You have to do it

twice. Once between $4,500 and $5,800, and then it goes to 90 percent. I am convinced, I say to my friend, there will be some administrative savings here.

Also I would make the point that because this bill—I know he agrees with me on this—relies too much on the private sector, the administrative costs are sky high. Medicare runs a 3 percent administrative cost. The private sector runs between 15 and 25 percent. As a matter of fact, in the House bill they are saying it is a 25 percent cost of the entire bill.

So I say to my friend, this particular amendment is not that large a cost when you really look at administrative costs going in.

The reason I do not offset it, I say to my friend, is because I think our smart Senators and their smart staffs can sit down and figure out a way to pay for this thing where you can take a lot out of administration. I just wonder if my friend agrees that the complication involved here is worth removing.

Mr. KENNEDY. Well, the complication is costly. We know for a fact we spend $5,000 on health care for every man, woman, and child. We are spending $1.4 trillion a year for every man, woman, and child in America at the present time. That is even before we get into this. Forty percent out of every health care dollar is nonclinical. It is nonclinical. There is not an industry in the world that has that kind of, effectively, overhead.

If we reduce that from 40 cents to 35 cents, it would be $70 billion a year. If we took it down to 30 cents, which is not unreasonable, that would be $140 billion a year. It gives you some idea of what is in the health care system that is not really being translated into good kinds of services. And that is a very important issue and question.

I think the Senator is right, that there is a very high administrative cost generally in terms of our health care system, and there are things that can be done about it. I hope we will have the chance to address those. We have some ideas. But I must say, now the question really has to do with the questions of priorities, about how we are going to act. The fact is, we have the amount that is in the budget which is only the $400 billion, and you stretch it and stretch it, and pull it and pull it, and you get this kind of result. It isn't the kind of result that would be there if the Senator from California drafted the bill or if I drafted the bill, but this is where we are. I am going to do everything I possibly can to make sure we are going to have a complete system.

I thank the Senator.

AMENDMENT NO. 976

Mr. President, I know we are going to go to a vote at 11 o'clock. I would like to take just a minute on the amendment we are going to be voting on. As I understand it, it is the Rockefeller amendment that will be directed toward the retiree issue.

One of the great strengths of Medicare is that it is for everyone. Rich and poor alike contribute to the system. Rich and poor alike benefit from it.

At bottom, Medicare is a commitment to every senior citizen and every disabled American that we will not have two-class medicine in America. When a senior citizen enters a hospital, Medicare pays the same amount for their care whether they are a pauper and a millionaire. When a senior citizen goes to a doctor, she has the peace of mind of knowing that Medicare has the same obligation to pay for her treatment no matter what her financial circumstances and the doctor has no financial interest in rationing her care according to the contents of her bank account.

Through the Medicaid program, we do try to provide extra help for those who are poor. But the fact that Medicaid provides extra assistance for the poor does not reduce Medicare's obligation to provide equal treatment for all. Medicare always has primary payment responsibilities for the services it covers. Medicaid is always supplementary.

Medicaid provides critical help to the poor and the elderly, but it does not provide the same reliable guarantees of equal treatment that Medicare does. Under Medicaid, States have limited the number of days of hospital care they would provide or the number of doctors' visits they will support. States have placed arbitrary limits on the number of prescriptions.

This legislation sets an undesirable precedent for treatment of poor senior citizens who are eligible for both Medicare and Medicaid. For every other benefit, these senior citizens enroll in Medicare, and Medicaid supplements Medicare's coverage. But for this benefit, the bill says that the poor are excluded from Medicare. The only benefits they get are from the Medicaid program. Medicare is for all senior citizens who paid into the program during their working years not just some senior citizens. And it should stay that way.

This amendment rights this wrong. It says we will not take away the Medicare that the poor have earned by a lifetime of hard work. It deserves the support of the Members. I hope it is adopted.

The PRESIDING OFFICER. The Senator from North Dakota.

AMENDMENT NO. 1002

Mr. CONRAD. Mr. President, I rise to speak on the amendment of my colleague from Arkansas. This is an amendment we brought up in the Finance Committee.

Mr. SANTORUM. Mr. President, will the Senator from North Dakota yield for a unanimous consent request?

Mr. CONRAD. I am happy to yield.

Mr. SANTORUM. Mr. President, the managers of the bill have asked we enter a unanimous consent agreement that the time between 10:50 and 11 o'clock be equally divided on the Rockefeller amendment.

The PRESIDING OFFICER. Is there objection?

Mr. CONRAD. Mr. President, I would object to that because I don't want to be taken off my feet when I am finishing the presentation on our amendment. It is going to take me more than 2½ minutes, so I object to that.

The PRESIDING OFFICER. Objection is heard.

Mr. SANTORUM. I say to the Senator, let me know, if there is maybe 8 minutes equally divided, would you have time to do that?

Mr. CONRAD. I would be happy to do that.

Mr. SANTORUM. Mr. President, I ask unanimous consent that we have 8 minutes equally divided, starting at 10:52.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. CONRAD. Mr. President, as I stated earlier on the Senate floor, I believe the bill before us is a step in the right direction. It provides much-needed and long-awaited prescription drug assistance to Medicare beneficiaries across the Nation. I commend Senator GRASSLEY and Senator BAUCUS for putting this proposal together.

But while I support this effort, I also recognize its shortcomings. I think one of the biggest weaknesses of this bill—other than the fact that it is not the kind of full prescription drug plan that many had hoped for because there are not sufficient dollars to support such a plan—is the fact this underlying legislation has too much instability. It creates confusion.

We could have a senior being in four different plans in 4 different years. And if there is anything I think we know, it is that seniors want certainty. They want to know what they are getting. But under this plan, seniors could be bounced back and forth between different plans, depending upon how many private drug-only plans enter an area. That is the first problem. If a senior is in a fallback plan and two private plans enter the area, they will be forced to leave a plan they may like, and they have no choice in the matter.

The second problem is, every time they switch between drug-only and fallback plans, their benefits could change. This chart demonstrates that uncertainty. Premiums are uncertain. Deductibles are uncertain. The coinsurance, coverage gap, the covered drugs, and even access to local pharmacies with no extra charge—all of those things are subject to change.

The third issue is this very ability isn't just a problem that could occur when a senior goes from a drug-only plan to a so-called fallback plan. It could also happen if seniors go from one fallback plan to another.

When you add this all up, this is the type of situation a senior could face, as shown on this chart. The Senator from Arkansas earlier used this chart. It shows what could happen to a senior being in four different plans in 4 different years, with different premiums,

with different copays, with different formularies—that is, different drugs being covered—with different rules with respect to whether they can use their local pharmacy without additional cost.

All of these are subject to change from year to year. Every one of these—the premiums, the deductibles, the coinsurance, the coverage gap, the drugs that are covered—is subject to change. That is not the circumstance we want to construct for our seniors.

In one year of this benefit, only one drug-only plan enters a region. A senior enrolls in the fallback plan to get drug coverage. In 2007, another private plan enters, and the senior is compelled to leave the fallback plan. Whether they like that plan or don't like it, they are forced to leave it.

In the third year, we might see private plan A leave the program and the senior then be put in private plan B, again with different rules, with different copays, with different premiums, with a different coverage gap. And then again, if private plan B left the area, they could again be in a different fallback plan—four different plans in four different years.

I am particularly concerned that rural seniors could face the situation I just described. To date, private plans have not had much interest in coming into those areas. Only 2 percent of rural counties had two or more Medicare+Choice plans in August of 2001.

This amendment seeks to create more stability and to provide the kind of certainty our seniors want. I hope my colleagues will look upon this plan with favor.

I ask unanimous consent that a letter from the National Council on the Aging endorsing this amendment be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

THE NATIONAL COUNCIL
ON THE AGING,
Washington, DC, June 23, 2003.

Hon. BLANCHE LINCOLN,
Dirksen Senate Office Building,
Washington, DC.

DEAR SENATOR LINCOLN: The National Council on Aging (NCOA)—the Nation's first organization formed to represent America's seniors and those who serve them—supports the amendment you are offering along with Senator Conrad to provide for a two-year contract cycle for the fallback plan in the Senate Medicare proposal.

It is clear from the prescription drug proposal being considered in the Senate that beneficiaries desperately need more stability and less confusion. We are concerned that under the structure currently proposed, vulnerable seniors could be forced to ping-pong back and forth every year from one plan to another—plans with potentially much different premiums, benefit structures, and formularies. We must do everything possible to avoid this kind of instability and confusion, which upset far too many seniors in recent years who enrolled in Medicare+Choice programs. This unfortunate experience must not be repeated.

We deeply appreciate the fact that, unlike the House bill, the Senate bill includes a failsafe mechanism to ensure that prescription drug coverage is guaranteed for every beneficiary choosing to participate.

Given the authority and flexibility in the Senate proposal to negotiate with private plans to reduce their risk in an effort to encourage their participation, we do not expect a significant number of beneficiaries to need the fallback plan. However, in those instances when it is necessary to guarantee access to drug coverage, seniors should not be disadvantaged by subjecting them to a system that could be disruptive and disturbing.

Thank you for your efforts and leadership on behalf of America's seniors. We urge Senators to support your amendment, which will further enhance the stability and fairness of the Senate Medicare proposal.

Sincerely,

JAMES FIRMAN,
President and CEO.

AMENDMENT NO. 976

The PRESIDING OFFICER. Under the previous order, there are 8 minutes of debate evenly divided on the Rockefeller amendment. Who yields time?

Mr. DODD. Mr. President, I ask to be yielded 2 minutes of the 4 minutes on the Rockefeller amendment.

The PRESIDING OFFICER. Who yields time?

Mr. ROCKEFELLER. Mr. President, I yield 3 minutes to the Senator from Connecticut.

The PRESIDING OFFICER. The Senator from Connecticut is recognized for 3 minutes.

Mr. DODD. Mr. President, I thank my distinguished friend and colleague from West Virginia.

I hope the body will support this amendment. I have spoken about the bill generally and expressed my optimism about it despite the serious shortcomings I have. It is a major step in the right direction. We can enhance that by adopting what Senator ROCKEFELLER is offering us today: The ability to ensure that employers will continue to offer prescription drug coverage for their retirees.

What we don't want to do, as we move forward with this program, is to supplant existing retiree programs. That would be a great setback for us. The bill, as presently crafted, does not count payments made by the retiree benefit plan that are out-of-pocket expenditures by the individual beneficiary. This will vastly increase the amount of money an employer will have to pay in order to act as an effective supplement to the Medicare drug benefit, a so-called wraparound to Medicare. In other words, this bill would actually discourage employers from playing even that reduced role in terms of prescription drugs.

The Rockefeller amendment will address this problem so that employer contributions are counted toward an individual's out-of-pocket costs. We will offer an amendment ourselves that would add even a bit more. But this is a major amendment and a critical one. It would be a great irony indeed, as we move forward with our plan, that we end up discouraging employers from participating, as they have, in providing their retirees with the kind of protections they need. It would actually cost them more. It is very important we adopt this amendment. This is a critically important question.

Even before we got into this whole business, the benefits being provided by employers, by nonprofits, and others have been important in terms of enhancing a retiree's ability to pay for prescription drugs and not have to make the choice of food on the table or prescription drugs or to self-medicate by reducing the amount of prescription drugs they get. No one in this place wants to be a party to actually encouraging employers to step away from the very important part they already play in providing these benefits for their employees and retirees.

I thank the Senator from West Virginia. It is a very important amendment. I strongly endorse it and hope it will be adopted.

Ms. MIKULSKI. Mr. President, I rise in support of the amendment No. 976 offered by Senator ROCKEFELLER to protect retirees from losing their hard won health care benefits. I also support amendment No. 998 offered by Senator DODD to encourage employers to continue to provide retirees with health care coverage.

I have seen how a community is devastated when a company pulls the retiree health care plan out from under their feet. Last year, when Senator ROCKEFELLER and I worked on adding steel retirees to the trade adjustment assistance health care tax credit, the writing was on the wall for Bethlehem Steel. A once proud company, that was the backbone of several communities in Maryland, West Virginia, New York, and Pennsylvania had been crippled by illegal dumping of foreign steel.

Now Bethlehem Steel is no more and nearly 20,000 of their retirees and their families in Maryland, nearly 100,000 total, are left without the health care for which they worked their whole lives. We provided some relief for these retirees.

But we cannot let other retirees face the fear of losing their health care; face going bankrupt trying to afford their drugs, or face a confusing new system.

This legislation does not privatize Medicare: it does not coerce seniors to leave the Medicare they trust to get the drugs they need. Yet it does rely too heavily on private insurance companies. It should be a benefit for seniors and not a benefit for insurance companies that have let seniors down so many times before. Yet it puts the health care benefits of millions of seniors in jeopardy by creating an incentive for employers to drop retiree health care coverage.

That is why I will join my colleagues in offering amendments to strengthen the bill.

What would this amendment do?

CBO, our nonpartisan, unbiased analyst tell us that 37 percent of seniors with employer-sponsored coverage will lose that coverage if this bill is passed.

These retirees earned their retiree health care benefits. The benefit payments made on their behalf should be counted as their contributions toward the catastrophic cap. They earned their health care coverage. It is a part of their benefit package as a worker and should count just as the wages they pay for their prescription drugs count.

Why is this amendment important?

Employers want to do the right thing but are being squeezed at the bottom line. Prescription drug costs account for about 40 percent to 60 percent of employer retiree health care costs. What does that mean for U.S. employers? U.S. employers face competition from overseas where the cost of health care, including prescription drugs, is subsidized by the Government. What does this mean for U.S. retired workers? Unless this amendment is adopted, a senior could have closer to $10,000 in drug costs before they get the relief of the catastrophic cap. Unless this amendment is adopted millions of seniors could lose their retiree health care coverage.

Under some estimates, this bill would give insurance companies up to $25 billion to provide drug benefits to seniors. Yet thousands of employers already provide quality health care benefits to their retirees, benefits that include prescription drugs.

Congress should use the same test as a doctor would: Do no harm.

In passing this bill, we could decimate the ability of employers to provide health care coverage for their retirees. I think we should fix this.

In conclusion, I urge my colleagues to stand up for American businesses, stand up for America's workers, and stand up for America's seniors and support this amendment.

The PRESIDING OFFICER. Who yields time?

The Senator from Pennsylvania.

Mr. SANTORUM. Mr. President, I hear often from many on the other side of the aisle that the Republican Party is the party of big corporations and corporate bailouts: This is a $66 billion, big corporation bailout being offered by Members on the other side of the aisle, $66 billion to corporate America that is already getting a huge benefit under this bill. We are already, by providing prescription drugs to all retirees, giving them the ability to basically back away, as has been discussed, from providing basic prescription drugs and still add on, if they want to add on additional benefits to the bottom line benefit. The cost savings already in the bill to corporations are in the billions and billions of dollars. But that is not enough. We have to give big corporate America another $66 billion so they can provide even more generous benefits to their retirees on top of the generous benefit we have in this legislation.

I find it almost incomprehensible that we are arguing that at a time when we are providing literally tens of billions of dollars—maybe even more than that—to corporate America to help relieve some of their retiree health care costs, now we have to add $66 billion more over the next 10 years to corporate America.

This is a very unwise amendment. It is a very costly amendment, $66 billion. In addition, you are seeing already that corporate America is getting out of the retiree health care business because it is very expensive. One of the reasons we are moving forward with this legislation is because of that. We have seen the percentage of retiree health plans drop from 71 percent to 44 percent just in the last 15 years. This is a trend that is ongoing. One of the reasons we are stepping in with this universal benefit is to address that issue.

To in effect provide an additional amount of money to corporations to basically help them maintain their effort in this area is a folly. It is a very costly proposal and should be, hopefully, defeated.

I reserve the remainder of my time.

The PRESIDING OFFICER. The Senator from West Virginia.

Mr. ROCKEFELLER. Mr. President, the argument made by the Senator from Pennsylvania is interesting because what he is basically saying is that it is more important that corporate America not be allowed to keep one out of three of their people they currently sponsor, who are retirees who worked for them and who have been getting health benefits from them, out of the picture.

He talked about the cost to corporate America. My sort of worry is about the cost to the U.S. Government. That is what we do if we don't pass my amendment; we just dump everything on the U.S. Government.

So this amendment will make sure we do not jeopardize the drug coverage of millions of retirees, one out of every three, who already receive drug coverage from employer-sponsored plans. This amendment is going to ensure that the contributions made on the beneficiaries' behalf by their former employers count toward that beneficiary meeting the catastrophic limit. That is not now the case.

Employer-sponsored retiree health benefits are the single greatest source of coverage for retirees—the Presiding Officer understands what I am saying—the single greatest source of retiree health benefits available. In fact, 37 percent of all retirees who have corporate-sponsored plans simply lose them if this does not pass.

The PRESIDING OFFICER. Time has expired.

Mr. ROCKEFELLER. I hope we will pass my amendment. It is worse for employees. It is worse for employers. I hope my colleagues will support the amendment.

Mr. REID. Have the yeas and nays been ordered?

The PRESIDING OFFICER. That is correct.

The Senator from Pennsylvania has 1 minute 39 seconds remaining of the majority time.

Mr. SANTORUM. Mr. President, under the existing legislation, employers are allowed to continue to offer benefits to their employees. Many will. Many will change the structure of the benefit in which they offer to wrap around the existing Medicare benefit, as they do now with Medicare.

Their retiree insurance plans currently wrap around the existing Medicare plan. Future retiree plans will wrap around. Giving corporations $66 billion over the next 10 years as an incentive to give more generous benefits is nothing but a corporate giveaway and costs the taxpayers literally billions of dollars. It is an unwise transfer of Government dollars, taxpayer dollars to big corporations, that already have very generous health care plans, as well as retirement plans. It is not focused on what we should be focusing on here, which is the poorest of the poor.

Mr. President, I move to table the amendment and ask for the yeas and nays.

The PRESIDING OFFICER (Mr. ENZI). Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to the motion. The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. MCCONNELL. I announce that the Senator from Nebraska (Mr. HAGEL) and the Senator from Indiana (Mr. LUGAR) are necessarily absent.

Mr. REID. I announce that the Senator from Delaware (Mr. BIDEN), the Senator from Florida (Mr. GRAHAM), and the Senator from Massachusetts (Mr. KERRY) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote ''nay''.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 52, nays 43, as follows:

[Rollcall Vote No. 233 Leg.]

YEAS—52

Alexander	Crapo	Miller
Allard	DeWine	Murkowski
Allen	Dole	Nickles
Baucus	Domenici	Roberts
Bennett	Ensign	Santorum
Bond	Enzi	Sessions
Breaux	Fitzgerald	Shelby
Brownback	Frist	Smith
Bunning	Graham (SC)	Snowe
Burns	Grassley	Specter
Campbell	Gregg	Stevens
Chafee	Hatch	Sununu
Chambliss	Hutchison	Talent
Cochran	Inhofe	Thomas
Coleman	Kyl	Voinovich
Collins	Lott	Warner
Cornyn	McCain	
Craig	McConnell	

NAYS—43

Akaka	Daschle	Inouye
Bayh	Dayton	Jeffords
Bingaman	Dodd	Johnson
Boxer	Dorgan	Kennedy
Byrd	Durbin	Kohl
Cantwell	Edwards	Landrieu
Carper	Feingold	Lautenberg
Clinton	Feinstein	Leahy
Conrad	Harkin	Levin
Corzine	Hollings	Lieberman

Lincoln	Pryor	Schumer
Mikulski	Reed	Stabenow
Murray	Reid	Wyden
Nelson (FL)	Rockefeller	
Nelson (NE)	Sarbanes	

NOT VOTING—5

Biden	Hagel	Lugar
Graham (FL)	Kerry	

The motion was agreed to.

Mr. GRASSLEY. Mr. President, I move to reconsider the vote.

Mr. HATCH. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 984, AS MODIFIED

Mr. GRASSLEY. It is my understanding that the Senator from New Mexico is ready to modify his amendment. With the modification, I accept that amendment. We would not have a vote. I urge we proceed to the amendment of the Senator from New Mexico for consideration of his modification.

Mr. BUNNING. Reserving the right to object, could we at least understand what the modification is.

Mr. GRASSLEY. The Senator from New Mexico will explain that.

Mr. BINGAMAN. Mr. President, when I came to the Senate floor a few minutes ago, we were just informed by the Republican staff that CBO estimates the amendment we were planning to vote on would cost $5 billion. This is all brandnew information. It is erroneous information, but I have no way to contradict what CBO is saying.

Therefore, I send an amendment to the desk to modify my amendment to request a study by MedPAC on this issue which would come back to us within a year. At that point, we could make a determination as to whether we want to take the action I had originally been proposing. Let me explain.

I ask unanimous consent that I be allowed to modify my amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment (No. 984), as modified, is as follows:

After section 404, insert the following:

SEC. 404A. MEDPAC STUDY AND REPORT REGARDING MEDICARE DISPROPORTIONATE SHARE HOSPITAL (DSH) ADJUSTMENT PAYMENTS.

(a) STUDY.—The Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6) (in this section referred to as ''MedPAC'') shall conduct a study to determine, with respect to additional payment amounts paid to subsection (d) hospitals under section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F))—

(1) whether such payments should be made in the same manner as payments are made with respect to graduate medical education under title XVIII and with respect to hospitals that serve a disproportionate share of low-income patients under the medicaid program; and

(2) whether to add costs attributable to uncompensated care to the formula for determining such payment amounts.

(b) REPORT.—Not later than 1 year after the date of enactment of this Act, MedPAC shall submit a report to Congress on the study conducted under subsection (a), together with such recommendations for legislation as MedPAC determines are appropriate.

Mr. BINGAMAN. Mr. President, the issue to which this study will give the answer is the question of whether disproportionate share hospitals that are the same net hospitals, that serve many of the individuals who would not have any health insurance, should continue to receive the DSH payments we have legislated they are entitled to, even after this prescription drug legislation becomes law. I strongly believe they should. My amendment was intended to ensure they receive those payments.

I fear the system we are adopting, which will move people into preferred provider organizations, will in fact reduce the payments to these disproportionate share hospitals, which I don't believe is the purpose or the intention of the Senate. That is the issue.

I urge my colleagues to support the study to give an answer as to whether that problem exists.

Mr. GRASSLEY. As I indicated, we accept that amendment, and I would like to have it adopted on a voice vote.

Mr. BAUCUS. Mr. President, it is unfortunate we did not get the score on the Senator's amendment until just recently. The chairman and I have been in constant contact. I have called several times today the CBO Director in order to get the scores in time for amendments. The good news is Senators have come to us so we are able to prioritize amendments and therefore calls to CBO are on amendments that will be sequenced so we can help them get the scores. We are trying our best to get CBO scores. The Senators can help us and help CBO get the scores by getting amendments to us early so we can sequence them.

On the other hand, it is very helpful if CBO can work as diligently as possible themselves and live up to their side of the bargain and get the scores to us. I hope we do not face this situation again where we get the score moments before an amendment is voted on, even though CBO knew this amendment was coming up; they had at least 24 hours' advance notice.

The PRESIDING OFFICER. The question is on agreeing to the amendment.

The amendment (No. 984), as modified, was agreed to.

Mr. GRASSLEY. We have had so many Democrat amendments that have been offered. We have reserved time for Republicans to fit in. It is my understanding that Senator SMITH of Oregon is prepared to offer an amendment from our side. I ask unanimous consent that Senator SMITH be recognized.

Mr. REID. Reserving the right to object, will there be a unanimous consent offered for sequencing votes later this afternoon?

Mr. GRASSLEY. Mr. President, in answer to the distinguished Democrat whip, there is an effort being made at the staff level to put together a series of votes. In further response, we are not prepared at this point to ask unanimous consent, but we will have such a request to make for stacking of votes and an order for votes.

Mr. REID. For the information of Senators, my understanding is that the two leaders want to have a series of votes starting at 2:25 this afternoon; is that right?

Mr. GRASSLEY. That is my understanding.

The PRESIDING OFFICER. The Senator from Oregon.

AMENDMENT NO. 962

Mr. SMITH. Mr. President, I ask unanimous consent that the pending amendment be set aside and I send an amendment to the desk.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report.

The legislative clerk read as follows:

The Senator from Oregon [Mr. SMITH], for himself and Mr. BINGAMAN, proposes an amendment numbered 962.

Mr. SMITH. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To provide reimbursement for Federally qualified health centers participating in medicare managed care)

At the end of title VI, insert the following:

SEC. ___. REIMBURSEMENT FOR FEDERALLY QUALIFIED HEALTH CENTERS PARTICIPATING IN MEDICARE MANAGED CARE.

(a) REIMBURSEMENT.—

(1) IN GENERAL.—Section 1833(a)(3) (42 U.S.C. 1395*l*(a)(3)) is amended to read as follows:

''(3) in the case of services described in section 1832(a)(2)(D)—

''(A) except as provided in subparagraph (B), the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such services (other than for items and services described in section 1861(s)(10)(A)) exceed 80 percent of such costs; or

''(B) with respect to the services described in clause (ii) of section 1832(a)(2)(D) that are furnished to an individual enrolled with a MedicareAdvantage plan under part C pursuant to a written agreement described in section 1853(j), the amount by which—

''(i) the amount of payment that would have otherwise been provided under subparagraph (A) (calculated as if '100 percent' were substituted for '80 percent' in such subparagraph) for such services if the individual had not been so enrolled; exceeds

''(ii) the amount of the payments received under such written agreement for such services (not including any financial incentives provided for in such agreement such as risk pool payments, bonuses, or withholds),

less the amount the Federally qualified health center may charge as described in section 1857(e)(3)(C);''.

(b) CONTINUATION OF MEDICAREADVANTAGE MONTHLY PAYMENTS.—

(1) IN GENERAL.—Section 1853 (42 U.S.C. 1395w–23), as amended by this Act, is amended by adding at the end the following new subsection:

''(j) PAYMENT RULE FOR FEDERALLY QUALIFIED HEALTH CENTER SERVICES.—If an individual who is enrolled with a

MedicareAdvantage plan under this part receives a service from a Federally qualified health center that has a written agreement with such plan for providing such a service (including any agreement required under section 1857(e)(3))—

''(1) the Secretary shall pay the amount determined under section 1833(a)(3)(B) directly to the Federally qualified health center not less frequently than quarterly; and

''(2) the Secretary shall not reduce the amount of the monthly payments to the MedicareAdvantage plan made under section 1853(a) as a result of the application of paragraph (1).''.

(2) CONFORMING AMENDMENTS.—

(A) Paragraphs (1) and (2) of section 1851(i) (42 U.S.C. 1395w–21(i)(1)), as amended by this Act, are each amended by inserting ''1853(j),'' after ''1853(i),''.

(B) Section 1853(c)(5) is amended by striking ''subsections (a)(3)(C)(iii) and (i)'' and inserting ''subsections (a)(3)(C)(iii), (i), and (j)(1)''.

(c) ADDITIONAL MEDICAREADVANTAGE CONTRACT REQUIREMENTS.—Section 1857(e) (42 U.S.C. 1395w–27(e)) is amended by adding at the end the following new paragraph:

''(3) AGREEMENTS WITH FEDERALLY QUALIFIED HEALTH CENTERS.—

''(A) PAYMENT LEVELS AND AMOUNTS.—A contract under this part shall require the MedicareAdvantage plan to provide, in any contract between the plan and a Federally qualified health center, for a level and amount of payment to the Federally qualified health center for services provided by such health center that is not less than the level and amount of payment that the plan would make for such services if the services had been furnished by a provider of services that was not a Federally qualified health center.

''(B) COST-SHARING.—Under the written agreement described in subparagraph (A), a Federally qualified health center must accept the MedicareAdvantage contract price plus the Federal payment provided for in section 1833(a)(3)(B) as payment in full for services covered by the contract, except that such a health center may collect any amount of cost-sharing permitted under the contract under this part, so long as the amounts of any deductible, coinsurance, or copayment comply with the requirements under section 1854(e).''.

(d) SAFE HARBOR FROM ANTIKICKBACK PROHIBITION.—Section 1128B(b)(3) (42 U.S.C. 1320a–7b(b)(3)) is amended—

(1) in subparagraph (E), by striking ''and'' after the semicolon at the end;

(2) in subparagraph (F), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following new subparagraph:

''(G) any remuneration between a Federally qualified health center (or an entity controlled by such a health center) and a MedicareAdvantage plan pursuant to the written agreement described in section 1853(j).''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to services provided on or after January 1, 2006, and contract years beginning on or after such date.

Mr. SMITH. Mr. President, I rise today to offer this amendment that will protect the health care safety net and ensure access to quality health care for low-income Medicare beneficiaries who rely on our Nation's community health centers. I am pleased to be joined in this by my colleague from New Mexico, Senator BINGAMAN, who has been a strong advocate for the medically underserved. It is a privilege to work with him on this amendment.

This is an issue that affects the entire country, not just my State of Oregon. We all have community health centers. Health centers are the family doctor to more than 13 million people, more than 5 million of whom are uninsured, and nearly 1 million are low-income Medicare beneficiaries.

For many of these individuals, their local health center is the only accessible provider of preventive and primary health care services. While the centers receive Federal Public Health Service Act grant funds to support care for their uninsured patients, they rely on adequate payments from both Medicaid and Medicare for care provided to beneficiaries under both programs.

In 1990, Congress recognized the importance of protecting the integrity of the PHSA grant funds and required that health centers receive reasonable cost payments under the traditional Medicare Part B Program. This action on the part of Congress helped both to ensure that the health centers are reimbursed sufficiently for the provision of care to beneficiaries under the traditional Medicare program, and to protect access to health center services for the uninsured. The amendment we are proposing today simply would extend the same requirement to new Medicare Advantage Programs.

Specifically, the amendment would ensure that health centers are provided with a wraparound or supplemental payment, equal to the difference between the payments they now receive under Medicare generally and the payments they will receive from Medicare Advantage plans. This is not a new concept.

Under current Medicaid law, a health center is reimbursed by a managed care organization the equivalent of what the managed care organization pays any other provider of similar services. In turn, the State Medicaid Program provides a wraparound or supplemental payment for the difference between the managed care organization's payment and the health center's reasonable cost. The absence of a wraparound payment system in the current Medicare managed care program, Medicare+Choice, has left many health centers struggling to provide services to seniors under the program while trying to protect Federal grant funds intended to support care for the uninsured.

In 2001, health centers in my home State of Oregon lost more than $55 for each patient's office visit when they were enrolled under a Medicare managed care plan. In the same year, Oregon health centers lost almost as much revenue as they gained from the Medicare managed care patients. It is estimated this new percentage will grow even larger under the new Medicare Advantage Program. In fact, if current estimates are correct, health centers nationwide can expect to experience an average loss of $35 per office visit under the Medicare Advantage Program. Simply put, what this means is that without a wraparound payment system for health care centers contracting with Medicare Advantage plans, these centers will have no choice but to reach deep into their Federal grant funds, money that is supposed to go for care to the uninsured, in order to make up for the loss in Medicare payments. This will only serve to put further strain on health centers as well as the public safety net overall.

The President and the Congress have called upon this Nation to double the capacity of health centers and build a stronger primary care infrastructure for America's communities. America's health centers are trying to meet that challenge and still meet the health care needs of the Nation's growing uninsured.

In the last 3 years alone, health centers added more than 800,000 new uninsured patients to their roles, raising the number of uninsured Americans served by these centers to one in every eight Americans.

Our amendment would protect the vital mission of health centers to provide access to care to underserved rural and inner city communities. It would also bolster the goal of the President and the Congress to strengthen our health care safety net.

I have a letter in support of my amendment. I ask unanimous consent the letter be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

OREGON PRIMARY CARE ASSOCIATION,
Portland, OR, June 23, 2003.

Senator GORDON SMITH,
U.S. Senate, Russell Senate Office Building, Washington, DC.

DEAR SENATOR SMITH: On behalf of the 16 public and private, not-for-profit community health centers throughout the State of Oregon, I would like to extend our sincere gratitude for your sponsorship of the amendment to the Medicare reform bill which will implement ''wrap around'' payments for Federally Qualified Health Centers serving seniors under Medicare managed care.

As you know, Federally Qualified Health Centers (FQHCs) serve a critical role in their communities. In Oregon alone, more than 150,000 individuals rely on FQHCs for their primary health care needs each year. In the many rural areas of the state, in particular, FQHCs are often the only primary care providers available to serve Medicare, Medicaid and uninsured patients. The wrap around payments that you have proposed will ensure that FQHCs are adequately reimbursed for the cost of treating recipients of Medicare + Choice and the new Medicare Advantage program. Without adequate reimbursement for treating these Medicare managed care patients, FQHCs would be unable to continue to provide comprehensive, high-quality services to many of the seniors who rely on health centers for their care.

Senator Smith, our state is fortunate to have your leadership in Washington. Thank you again for your support and sponsorship of this measure that will significantly impact seniors and other underserved Oregonians being served by community health centers.

Sincerely,

CRAIG HOSTETLER,
Executive Director.

Mr. SMITH. Senator BINGAMAN and I are convinced that this amendment

goes a long way toward answering the concerns of health centers about how the Medicare Advantage Program will impact their ability to continue to provide high-quality health care services to their patients.

I thank my distinguished colleague from New Mexico for his efforts and his cosponsorship of this amendment and I urge all our colleagues to support it.

I yield the floor.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. BINGAMAN. Mr. President, I congratulate my colleague from Oregon for his leadership on this important issue. We have all worked on a bipartisan basis with the administration to increase our support for community health centers. We have all begun to recognize the very vital role they play in providing health care to many of our citizens throughout the country.

This amendment is absolutely crucial if we are going to ensure that the unintended effect of the legislation before us is not to drain funds away from community health centers as more and more people decide they want to sign up for these preferred provider organizations.

This is crucial legislation. It is very important we do this in the case of the Medicare prescription drug area, just as we did in the case of Medicaid.

I again compliment my colleague and I am honored to be a cosponsor of this amendment.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. BYRD. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. TALENT). Without objection, it is so ordered.

PREWAR INTELLIGENCE INVESTIGATION

Mr. BYRD. Mr. President, the news is just on the wires that six British troops have been killed near Basra in Iraq. Every day—every day—brings us sad tidings of American and/or Allied troops being killed in Iraq.

How much longer—how much longer, Mr. President—are our American fighting men and women going to have to remain in harm's way in a foreign land? How much longer are our National guardsmen and women and reservists going to have to be away from home?

The President announced not too long ago that major hostilities had ended. Were we told by this administration how long our military forces will be required to run these terrible risks that daily confront them in this biblical land of Mesopotamia, land between the two great rivers? I often asked the question, before the war began, What is going to be the cost? What is the plan? What is the administration's plan? What about the morning after the war ends?

No announcement has been made at this point that the war has ended, only that major hostilities no longer exist. And then there were public disagreements as to how many Americans would be needed in Iraq to bring about a safe and secure society.

I try to put myself in the place of a father or a husband of one of our military personnel in Iraq. I try to imagine the pain and the suffering on the part of those who wait—who wait—at home for the return of their loved ones.

Last fall, the White House released a national security strategy that called for an end to the doctrines of deterrence and containment that have been a hallmark of American foreign policy for more than half a century.

This new national security strategy is based upon preemptive war—something unheard of in the past experiences, practices, and policies of our Nation—preemptive war against those who might threaten our security.

Such a strategy of striking first against possible dangers is heavily reliant upon interpretation of accurate and timely intelligence. If we are going to hit first, based on perceived dangers, the perceptions had better be accurate. If our intelligence is faulty, we may launch preemptive wars against countries that do not pose a real threat against us or we may overlook countries that do pose real threats to our security, allowing us no chance to pursue diplomatic solutions to stop a crisis before it escalates to war. In either case, lives could be needlessly lost. In other words, we had better be certain that we can discern the imminent threats from the false alarms.

Just 96 days ago, as of June 24, President Bush announced that he had initiated a war to ''disarm Iraq, to free its people and to defend the world from grave danger.'' The President told the world:

> Our nation enters this conflict reluctantly—yet, our purpose is sure. The people of the United States and our friends and allies will not live at the mercy of an outlaw regime that threatens the peace with weapons of mass [destruction].

The President has since announced that major combat operations concluded on May 1. He said:

> Major combat operations in Iraq have ended. In the battle of Iraq, the United States and our allies have prevailed.

Since then, Mr. President, the United States has been recognized by the international community as the occupying power in Iraq. And yet we have not found any evidence that would confirm the officially stated reason that our country was sent to war; namely, that Iraq's weapons of mass destruction constituted a grave threat to the United States—a grave threat to the United States.

We have heard a lot about revisionist history from the White House of late in answer to those who question whether there was ever a real threat from Iraq. But it is the President who appears to me to be intent on revising history.

There is an abundance of clear and unmistakable evidence that the administration sought to portray Iraq as a direct, deadly, and imminent threat to the American people. But there is a great difference between the handpicked intelligence that was presented by the administration to Congress and the American people when compared against what we have actually discovered in Iraq. This Congress and the American people, who sent us here, are entitled to an explanation from this administration.

On January 28, 2003, President Bush said in his State of the Union Address:

> The British Government has learned that Saddam Hussein recently sought significant quantities of uranium from Africa.

Yet, according to news reports, the CIA knew this claim was false as early as March 2002. In addition, the International Atomic Energy Agency has since discredited this allegation.

On February 5, Secretary of State Colin Powell told the United Nations Security Council:

> Our conservative estimate is that Iraq today has a stockpile of between 100 and 500 tons of chemical weapons agents. That is enough to fill 16,000 battlefield rockets.

But, the truth is, to date we have not found any of this material, nor those thousands of rockets loaded with chemical weapons.

On February 8, President Bush told the Nation:

> We have sources that tell us that Saddam Hussein recently authorized Iraqi field commanders to use chemical weapons—the very weapons the dictator tells us he does not have.

Well, I say to my fellow Senators, we are all relieved that such weapons were not used, but it has not yet been explained why the Iraqi Army did not use them. Did the Iraqi Army flee their positions before chemical weapons could be used? If so, why were the weapons not left behind? Or is it that the army was never issued chemical weapons?

We need answers. We need answers to these and other such questions.

On March 16, the Sunday before the war began, in an interview with Tim Russert, Vice President CHENEY said the Iraqis want ''to get rid of Saddam Hussein and they will welcome as liberators the United States when we come to do that.'' Vice President CHENEY said the Iraqis want ''to get rid of Saddam Hussein and they will welcome as liberators the United States when we come to do that.''

He added:

> . . . the vast majority of them would turn Saddam Hussein in in a minute if, in fact, they thought they could do so safely.

But, today Iraqi cities remain in disorder. Our troops are under attack as well as our allies. Our occupation government lives and works in fortified compounds, and we are still trying to determine the fate of the ousted murderous dictator.

On March 30, Secretary of Defense Donald Rumsfeld, during the height of the war, said of the search for weapons of mass destruction:

We know where they are. They're in the area around Tikrit and Baghdad and east, west, south, and north somewhat.

Well, Mr. President, Baghdad fell to our troops on April 9 and Tikrit on April 14, and the intelligence about which Secretary of Defense Rumsfeld spoke has not led us to any weapons of mass destruction. Whether or not intelligence reports were bent, stretched, or massaged to make Iraq look like an imminent threat to the United States, it is clear that the administration's rhetoric played upon the well-founded fears of the American public about future acts of terrorism. But upon close examination, many of these statements have nothing to do with intelligence because they are, at root, just sound bites based on conjecture. They are designed to prey upon public fear.

The face of Osama bin Laden morphed into that of Saddam Hussein. President Bush carefully blurred these images in his State of the Union Address. Listen to this quote from the President's State of the Union Address:

Imagine those 19 hijackers with other weapons and other plans—this time armed by Saddam Hussein. It would take one vial, one canister, one crate slipped into this country to bring a day of horror like none we have ever known.

Judging by this speech, not only is the President confusing al-Qaida and Iraq, but he also appears to give a vote of no confidence to our homeland security efforts. Isn't the White House the brains behind the Department of Homeland Security? Isn't the administration supposed to be stopping those vials, canisters, and crates from entering our country rather than trying to scare our fellow citizens half to death about them?

Not only did the administration warn about more hijackers carrying deadly chemicals, the White House even went so far as to suggest that the time it would take for U.N. inspectors to find solid smoking gun evidence of Saddam's illegal weapons would put the United States at greater risk of nuclear attack from Iraq.

National Security Adviser Condoleezza Rice was quoted as saying on September 9, 2002, by the Los Angeles Times:

We don't want the ''smoking gun'' to be a mushroom cloud.

''Threat by Iraq Grows,'' this is the headline that was in the Los Angeles Times.

Well, talk about hype. Mushroom clouds? Where is the evidence for this? Where is the evidence for that hype? There isn't any.

On September 26, 2002, just 2 weeks before Congress voted on the resolution to allow the President to invade Iraq and 6 weeks before the midterm elections, President Bush himself built the case that Iraq was plotting to attack the United States.

After meeting with members of Congress on that date, the President said:

The danger to our country is grave. The danger to our country is growing. The Iraqi regime possesses biological and chemical weapons. . . . The regime is seeking a nuclear bomb, and with fissile material, could build one within a year.

Well, these are the President's words. He said that Saddam Hussein is seeking a nuclear bomb. Have we found any evidence to date of this chilling allegation? No.

But President Bush continued on that autumn day:

The dangers we face will only worsen from month to month and from year to year. To ignore these threats is to encourage them. And when they have fully materialized, it may be too late to protect ourselves and our friends and our allies. By then, the Iraqi dictator would have the means to terrorize and dominate the region. Each passing day could be the one on which the Iraqi regime gives anthrax or VX—nerve gas—or some day a nuclear weapon to a terrorist ally.

Yet, 7 weeks after declaring victory in the war against Iraq, we have seen nary a shred of evidence to support the President's claims of grave, dangerous chemical weapons, links to al-Qaida, or nuclear weapons.

Just days before a vote on a resolution that handed the President unprecedented war powers, President Bush stepped up the scare tactics. On October 7, just 4 days before the October vote in the Senate on the war resolution, the President had this to say:

We know that Iraq and the al-Qaida terrorist network share a common enemy—the United States of America. We know that Iraq and al-Qaida have had high-level contacts that go back a decade.

He continued:

We've learned that Iraq has trained al-Qaida members in bomb-making and poisons and deadly gases. . . . Alliance with terrorists could allow the Iraqi regime to attack America without leaving any fingerprints.

President Bush also elaborated on claims of Iraq's nuclear program when he said:

The evidence indicates that Iraq is reconstituting its nuclear weapons program. Saddam Hussein has held numerous meetings with Iraqi nuclear scientists, a group he calls his ''nuclear mujahideen''—his nuclear holy warriors. . . . If the Iraqi regime is able to produce, buy, or steal an amount of highly enriched uranium a little larger than a single softball, he could have a nuclear weapon in less than a year.

Wasn't that enough to keep you awake, Senators? This is the kind of pumped-up intelligence and outrageous rhetoric that was given to the American people to justify a war with Iraq. This is the same kind of hyped evidence that was given to Congress to sway its vote for war on October 11, 2002.

We hear some voices saying, well, why should we care? After all, the United States won the war, didn't it? Saddam Hussein is no more. Iraq is no longer a threat. He is either dead or on the run, so what does it matter if reality does not reveal the same grim picture that was so carefully painted before the war. So what. So what if the menacing characterizations that conjured up visions of mushroom clouds and American cities threatened with deadly germs and chemicals were overdone. So what.

Our sons and daughters who serve in uniform answered the call to duty. They were sent to the hot sands of the Middle East to fight in a war that has already cost the lives of 194 Americans to this moment, thousands of innocent civilians, and unknown numbers of Iraqi soldiers. Our troops are still at risk. Hardly a day goes by that there is not another attack on the troops who are trying to restore order to a country teetering on the brink of anarchy. When are they coming home?

The President told the American people we were compelled to go to war to secure our country from a grave threat. Are we any safer today than we were on March 18, 2003? Our Nation has been committed to rebuilding a country ravaged by war and tyranny, and the cost of that task is being paid for in blood and in treasure every day.

It is in the compelling national interest to examine what we were told about the threat from Iraq. This is not revisionist history. These words are plain English words that I have quoted. It is in the compelling national interest to know if the intelligence was faulty. It is in the compelling national interest to know if the intelligence was distorted. It is in the national interest to know if the intelligence was manipulated.

Mr. President, Congress must face this issue squarely. Congress should begin immediately an investigation into the intelligence that was presented to the American people about the prewar estimates of Saddam's weapons of mass destruction and the way in which that intelligence might have been misused. This is no time for a timid, tippy-toe Congress. Congress has a responsibility to act in the national interest and to protect the American people, and we must get to the bottom of this matter.

Although some timorous steps have been taken in the past few days to begin a review of this intelligence—I must watch my words carefully, for I may be tempted to use the word ''investigation'' or ''inquiry'' to describe this review, and those are terms which I am told are not supposed to be used—the proposed measures appear to fall short of what the situation requires. We are already shading our terms about how to describe the proposed review of intelligence: cherry-picking words to give the American people the impression that the Government is fully in control of the situation, and that there is no reason to ask tough questions. This is the same problem that got us into this controversy about slanted intelligence reports. Word games, lots and lots of word games.

This is no game. For the first time in our history, the United States has gone to war because of intelligence reports claiming that a country posed a threat to our Nation. Congress should not be content to use standard operating procedures to look into this extraordinary matter.

We should accept no substitute for a full, bipartisan investigation by Congress into the issue of our prewar intelligence on the threat from Iraq and the use of that intelligence.

The purpose of such an investigation is not to play preelection year politics, nor is it to engage in what some might call ''revisionist history.'' Rather, it is to get at the truth. The longer questions are allowed to fester about what our intelligence knew about Iraq, and when our intelligence knew it, the greater the risk that American people, whom we are elected to serve, will lose confidence in our Government.

This looming crisis of trust is not limited to the public. Many of my colleagues were willing to trust the administration and vote to authorize war against Iraq. Many Members of this body trusted so much that they gave the President sweeping authority to commence war. As President Reagan famously said, ''Trust, but verify.'' Despite my opposition, the Senate voted to blindly trust the President with unprecedented—unprecedented, unprecedented—power to declare war. Shame. While the reconstruction continues, so do the questions, and it is time to verify.

I have served the people of West Virginia in Congress for half a century. I have witnessed deceit and scandal, coverup and aftermath. I have seen from both parties Presidents who once enjoyed great popularity among the people leave office in disgrace because they misled the American people. I say to this administration: Do not circle the wagons. Do not discourage the seeking of truth in these matters.

The American people have questions that need to be answered about why we went to war with Iraq. To attempt to deny the relevance of these questions is to trivialize the people's trust and confidence.

The business of intelligence is secretive by necessity, but our Government is open by design. We must be straight with the American people. Congress has the obligation to investigate the use of intelligence information by the administration in the open so that the American people can see that those who exercise power, especially the awesome power of preemptive war, must be held accountable. We must not go down the road of coverup. That is the road to ruin.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Texas is recognized.

Mrs. HUTCHISON. Mr. President, I ask unanimous consent that the pending amendments be set aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 1004

Mrs. HUTCHISON. Mr. President, I ask that amendment No. 1004, which is at the desk, be called up.

The PRESIDING OFFICER. The clerk will report the amendment.

The bill clerk read as follows:

The Senator from Texas [Mrs. HUTCHISON] proposes an amendment numbered 1004.

Mrs. HUTCHISON. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To amend title XVIII of the Social Security Act to freeze the indirect medical education adjustment percentage under the medicare program at 6.5 percent)

At the end of subtitle A of title IV, add the following:

SEC. ___. FREEZING INDIRECT MEDICAL EDUCATION (IME) ADJUSTMENT PERCENTAGE AT 6.5 PERCENT.

(a) IN GENERAL.—Section 1886(d)(5)(B)(ii)(42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended—

(1) in subclause (VI), by striking ''and'' at the end; and

(2) by striking subclause (VII) and inserting the following new subclauses:

''(VII) during fiscal years 2003, 2004, 2005, 2006, 2007, and 2008, 'c' is equal to 1.35; and

''(VIII) on or after October 1, 2008, 'c' is equal to 1.6.''.

(b) CONFORMING AMENDMENT RELATING TO DETERMINATION OF STANDARDIZED AMOUNT.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended—

(1) by striking ''1999 or'' and inserting ''1999,''; and

(2) by inserting '', or the Prescription Drug and Medicare Improvement Act of 2003'' after ''2000''.

Mrs. HUTCHISON. Mr. President, today I rise, along with Senators KENNEDY, TALENT, BIDEN, KERRY, MURRAY, REED, SPECTER, BOND, CLINTON, FEINSTEIN, and DURBIN to offer an amendment for America's teaching hospitals.

The teaching hospitals in our country perform a vital role in training the doctors and nurses who conduct medical research and provide care to the needy. But the foundation of this essential public service is beginning to crack under the strain of Medicare reductions and a range of other financial pressures.

As my colleagues are aware, the Balanced Budget Act of 1997 made cuts to indirect medical education, called IME, which is an add-on for Medicare reimbursements to teaching hospitals. The add-on was reduced from 7.7 percent in 1997 to 6.5 percent in 1999. Further reductions were scheduled beginning in 2000, but those cuts were delayed until last October, and now the reimbursement rate has been dropped from 6.5 percent to 5.5 percent. That 1 percentage point means our Nation's teaching hospitals will lose almost $800 million this year, $4.2 billion over the next 5 years.

My amendment restores the reimbursement rate to 6.5 percent in fiscal year 2009. By putting this off until fiscal year 2009, of course, we are avoiding any Budget Act point of order.

There are 1,100 teaching hospitals in our country where Americans receive world-class care. Every State has at least one, so every Senator will have affected constituents. Teaching hospitals train nearly 100,000 doctors every year, and chances are, Mr. President, your physician and mine were trained at teaching hospitals.

In 1983, the Federal Government recognized that teaching hospitals cost more than their nonteaching counterparts because they incur costs to train our health care providers of the future. They provide clinical research in new procedures, technology, and treatments. Perhaps most importantly, they ensure a steady stream of high-quality physicians who are equipped to meet the health care challenges of the 21st century. They are also a major provider of indigent care in the United States. But education and training costs extra money.

The Government added the IME payment to encourage teaching hospitals to invest in our future, but, unfortunately, we have chipped away from 11.6 percent in 1983 to today's rate of 5.5 percent, which is a factor based on a hospital's resident-to-bed ratio included in Medicare reimbursement. We cannot continue to decimate funding at these hospitals that educate our medical students and expect quality medical care in the 21st century.

Teaching hospitals in Texas have lost $26.8 million in reimbursements in 2003 alone. Our State is not the hardest hit. New York lost $141 million; Pennsylvania, $78 million; and Michigan, $50 million.

One example in my State exemplifies what is happening in every teaching hospital in our country. Methodist Hospital in Houston trains more than 200 residents a year and works closely with Baylor College of Medicine to effectively train physicians in radiology, cardiology, and neurology with the newest technology. Methodist purchased an MRI machine for $4.5 million. That MRI will not only provide preventive medicine to help diagnose illnesses sooner, it also teaches the next generation of health care professionals what they cannot learn in the classroom.

This week, as we debate Medicare reform, it is imperative to reaffirm our commitment to America's teaching hospitals as these hospitals are in financial distress. If we do not restore funding, not only will they suffer, so will our health care system, particularly patient care.

I ask for the support for this amendment. I ask for the yeas and nays. I will ask for unanimous consent to stack the next two votes, but I also ask unanimous consent the vote on my amendment be in the next series of votes.

Mr. REID. Reserving the right to object, it is my understanding the Senator has asked that following the Dodd vote we vote on Pryor and Boxer.

Mrs. HUTCHISON. I was going to offer that unanimous consent.

Mr. REID. Did you ask unanimous consent on something else?

Mrs. HUTCHISON. I was going to ask unanimous consent for the Pryor amendment and the Boxer amendment and then ask my amendment be in the next series of votes.

Mr. REID. Mr. President, I reluctantly have to object. I personally

could care less, but until the two managers are here—unless you have cleared it with the two managers.

Mrs. HUTCHISON. No, I have not.

The PRESIDING OFFICER. The objection is heard.

The Senator from Texas has requested the yeas and nays. Is there a sufficient second? There is a sufficient second. The yeas and nays are ordered.

Mrs. HUTCHISON. I ask unanimous consent following the vote this afternoon in relation to the Dodd amendment No. 969, the Senate vote consecutively in relation to the following amendments: Pryor amendment 981, Boxer amendment 1001; provided further that there be 2 minutes equally divided between each of the votes with no amendments in order to the amendments prior to the vote.

Mr. REID. We do not object.

Mrs. HUTCHISON. And I ask the Democratic leader work with me to be in the next series of votes.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. I say to the distinguished Senator from Texas we will try to do that. It seems the right thing to do.

RECESS

The PRESIDING OFFICER. Under the previous order, the hour of 12:30 p.m. having arrived, the Senate will now stand in recess until the hour of 2:15 p.m.

Thereupon, the Senate, at 12:32 p.m., recessed until 2:15 p.m. and reassembled when called to order by the Presiding Officer (Mr. VOINOVICH).

PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003—Continued

AMENDMENT NO. 969

The PRESIDING OFFICER. Under the previous order, the hour of 2:15 having arrived, there will now be 10 minutes evenly divided prior to a vote in relation to the Dodd amendment, No. 969.

Mr. DODD. Mr. President, do I need to ask unanimous consent the present amendment be temporarily set aside?

The PRESIDING OFFICER. That is unnecessary.

Mr. DODD. Mr. President, in the 5 minutes I have, let me discuss it very briefly with my colleagues.

This amendment would allow Medicare beneficiaries the freedom to move between plans for the first 2 years that this benefit is in effect, from 2006 to 2007. Under the present bill, you have to make a decision immediately and then you are locked into that decision for a year. Then you would have an open enrollment period for a month after that, and then you would be locked in for another year.

What we are offering with this amendment is initially seniors be given a 2-year window in order to decide which plan works best for them. Then you would go to the 1 year with the 1-month open enrollment. But, initially, given the tremendous amount of potential confusion about which of these various alternatives would work best for people, they ought to be given a bit more time than to have to make an almost instantaneous decision about which of these plans is best suited for them.

One of the hallmarks that has been used to describe this bill is it is to give people choice—flexibility and choice. All we are suggesting is an additional 2 years, if you will, not requiring an immediate decision but a 2-year window in order to make that choice so people are more well informed.

There are a number of areas in the underlying bill that do not go nearly far enough, in my view, to serve Medicare beneficiaries. But I believe this is a good first step, at least as presently proposed. I am inclined to be supportive of this bill. These are some small points I think could help make this a better bill.

If enacted, the underlying bill would require, as I mentioned, Medicare beneficiaries to choose a prescription drug plan and to stay with that plan for a minimum of 1 year. With the enactment of such broad and sweeping changes in the Medicare Program, I am fearful many Medicare beneficiaries will face great uncertainty trying to find the best plan to meet their particular needs. Beneficiaries would be faced with a menu of plans offering varying premiums, copayments or coinsurance, drug formularies, and all the other variables that make up a prescription drug benefit. It may not be immediately clear to people over the age of 65 which of these plans is going to best suit their needs. It is not difficult to imagine a scenario where this could become a significant problem, possibly even affecting the health and well-being of the beneficiary we are trying to assist with this legislation.

A senior on a tight budget might enroll in a plan in an area that offers slightly lower premiums and coinsurance. Perhaps that beneficiary is on blood pressure medication and, after enrolling in the plan, discovers the particular medication—which she has been taking for years and has proven to be effective for a condition, with minimal side effects—is not part of the formulary for the plan she chose immediately.

What I am suggesting is, What are her options? As the bill is currently written, she is stuck with that plan for at least a year. So she can try to navigate the hurdles and obstacles that would allow her to take an off-formulary drug, or switch to another drug that might not be as effective or cause severe side effects. These are not optimal choices.

One of our stated goals is to give seniors as much of a choice as possible, and I am firmly behind that goal, as I mentioned at the outset of these remarks.

I do not want to suggest for a second that we should reduce choice or create simplicity, nor do I question the importance of cost-control mechanisms such as formularies. However, with choice and differentiation comes uncertainty. I believe we can greatly relieve this uncertainty by allowing those initially choosing prescription drug plans for the very first time the opportunity to move from one plan to another to determine which of these plans offers the best plan to fit their needs, and to give them the opportunity of doing that for a 2-year period, and then go to the open enrollment period and a 1-year after that.

I asked people in my own State to take a look at this proposal. In fact, this language comes from them. Their suggestion is this language I have on this chart. I will read from it:

> The amendment which you are proposing is essential to ensure fair and informed access to the health plans which are planned under the terms of S. 1.

By the way, these people are very much supportive of what Senator GRASSLEY is doing in this bill. They say:

> Our experience with Medicare beneficiaries in Connecticut and nationally has shown that the ability of a Medicare beneficiary to change from plan to plan, especially during the period after initially choosing a plan, is of utmost importance. Making choices about which health plan is best is often confusing for a Medicare beneficiary, especially for those who are elderly, frail or having medical problems. Comparing plans and choosing the right plan can be a complicated process, and Medicare beneficiaries who discover they have not made the most informed choice, whose experience with a plan demonstrates it is not adequate to meet their needs, or who have changes in their life circumstances, need to have some ability to change from one plan to another. Only with this ability to change can they be assured the opportunity to receive the kind of health care they want, and the fullest health benefit they need, to meet their individual circumstances under the Medicare program.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. DODD. Mr. President, I ask unanimous consent for 30 additional seconds.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. DODD. All we are asking is, instead of forcing people to make that initial decision, they be given that 2-year window to sort this out. And then you move into the 1 year and the window opens, and so forth. I do not think this has any significant financial implications. It is just allowing people to make intelligent, good choices which all of us want to provide people, particularly older Americans who could be terribly confused by choosing formularies and coinsurance and copayment plans. All that has to be done at the outset once this bill becomes law.

I have used a little more time than I said I would to try to explain the amendment, but I want it to be clear to my colleagues why I think this is a

very reasonable suggestion to make an improvement to this bill.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. DODD. I thank the Presiding Officer for his indulgence.

The PRESIDING OFFICER. Who yields time?

Mr. DODD. Mr. President, I ask unanimous consent that my colleague, Senator LIEBERMAN, be added as a cosponsor of this amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

Who yields time?

Mr. DODD. Mr. President, if they don't want to talk, I will be glad to take a little more time to explain this amendment.

Mr. GRASSLEY. Mr. President, I will yield the man 1 minute of my time.

Mr. DODD. Mr. President, I thank the man from Iowa for yielding the 1 minute.

The PRESIDING OFFICER. The Senator is recognized for 1 minute.

Mr. DODD. The man from Connecticut appreciates the man from Iowa giving him 1 more minute.

Mr. President, very briefly, the existing underlying bill says you have to make this choice about which plan you want to go into almost immediately once this proposal becomes law. We are suggesting that at the outset you give people a 2-year window to shop wisely. They may make the decision right away. They may make it within a month or two. But knowing how confusing this can be, knowing that different formularies provide for different medications, we ought to provide people at least some opportunity to get this right to the extent they can. So this is merely opening up that window from an immediate choice to a 2-year choice—anytime within that 2 years to make that right choice.

There have been some who wondered, if you move from one plan to the next, what are the cost implications? I will be glad to respond to that. We do not think that is terribly complicated to figure out. If you have reached your deductible levels, obviously, the same would have to apply. You would not start all over in that 1-year period. So whatever costs you have incurred, whatever expenditures you have made or not made would move from one plan to the next, at least as far as the cost goes.

So the additional time should not have any additional financial or fiscal implications but merely the choice of saying to people, who are older Americans: You get a little more time to sort this out. That is all I am suggesting with this amendment.

I would hope the committee might support it. It is not a radical proposal.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. DODD. I thank the Senator.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Mr. President, I yield myself such time as I might consume.

I know the Senator from Connecticut has well-intentioned motivations behind his amendment. The reason why I oppose the amendment is not because of any ill intent. But we have very carefully crafted this product before us after the Federal Employees Health Benefits Plan and the open season and the practice there. As far as I know, we do not run into Federal employees complaining because they cannot change more often than once a year. So I am going to ask my colleagues to vote against this amendment.

It has some costs. I will speak about that. The open enrollment period in S. 1, as I said, is modeled after the annual open enrollment period of the Federal Employees Health Benefits Plan. I believe this program has been in place for more than 40 years, so we have a lot of experience with it. Consequently, it is a good pattern for us to craft the legislation before us for senior citizens in retirement for their health benefits.

Each year seniors would be able to examine the choice of plans and select the plan that is best suited to their needs. The amendment before us proposes to allow seniors to change plans more than once during a continuous open enrollment period that would last for 2 years. While this may seem a good idea on the surface, it is an invitation, I believe, to more expensive health care for our seniors. I think it is going to lead to chaos and plan instability.

It is very important, at least in the opening years, as we get these new programs underway that there be some predictability in order to encourage more plans to compete. The more plans competing, the better benefits we ought to get for our seniors at a lower price.

It seems to me that providing a long, continuous open enrollment period allows any and all seniors to wait until they are sick before enrolling in a more comprehensive plan. You can understand that we need to have a situation where people are seen buying insurance and doing it in a way in which they manage their own risk as opposed to doing it in the case of only an emergency. This is where you get the insurance aspect that is so important in what we are trying to accomplish.

So if you do that, as the Senator from Connecticut suggests, it is going to add costs to the program because it permits healthy enrollees to stay in the cheaper basic plan until an illness drives them to a generous plan. The generous plan then would become the plan just for sick enrollees.

I have a statement here that the CBO says this would have a cost of $8 billion over the years 2004 to 2008, and $23 billion for the 10-year period 2004 to 2013.

I am going to yield back the remainder of my time.

The PRESIDING OFFICER. All time has expired.

Mr. DODD. I ask unanimous consent for an additional 30 seconds.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. DODD. Mr. President, this is one time. Unlike Federal employees, who are 30 or 35 years of age, this plan is all new. What we are saying is, for the very first 2 years—that is all, just the first 2 years—give seniors the flexibility so they do not have to sign up for a plan immediately. You get a couple years within that timeframe to make your choice, then you go into the 1-year cycle as all the rest of us do. But for older Americans, it is very confusing—very confusing—for them to have to make that choice at the get-go, right at the very beginning. So that 2-year window, to have some flexibility to make a choice that best serves your interest, I think is a reasonable request to make for our older Americans. That is the end of it.

Mr. GRASSLEY. Mr. President, I ask unanimous consent for an equal 30 seconds.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. GRASSLEY. Mr. President, I have some sympathy for what the Senator from Connecticut says because so many times I have said to my constituents, this is voluntary. You are going to have your choice to go into another plan or change plans. I emphasize the ability to change plans. In addition, we have to have some stability even in the early years. Most importantly, when we are developing a new prescription drug benefit, the most vast improvement in Medicare in 35 years, I think it demands more stability than when you get down the road a ways.

I move to table the amendment and ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to the motion to table amendment No. 969. The clerk will call the roll.

The bill clerk called the roll.

Mr. REID. I announce that the Senator from Florida (Mr. GRAHAM), the Senator from Massachusetts (Mr. KERRY), and the Senator from Connecticut (Mr. LEIBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote ''nay''.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 55, nays 42, as follows:

[Rollcall Vote No. 234 Leg.]

YEAS—55

Alexander	Chambliss	Fitzgerald
Allard	Cochran	Frist
Allen	Coleman	Graham (SC)
Baucus	Collins	Grassley
Bennett	Cornyn	Gregg
Bond	Craig	Hagel
Breaux	Crapo	Hatch
Brownback	DeWine	Hutchison
Bunning	Dole	Inhofe
Burns	Domenici	Jeffords
Campbell	Ensign	Kyl
Chafee	Enzi	Lott

Lugar	Santorum	Sununu
McCain	Sessions	Talent
McConnell	Shelby	Thomas
Murkowski	Smith	Voinovich
Nelson (NE)	Snowe	Warner
Nickles	Specter	
Roberts	Stevens	

NAYS—42

Akaka	Dorgan	Levin
Bayh	Durbin	Lincoln
Biden	Edwards	Mikulski
Bingaman	Feingold	Miller
Boxer	Feinstein	Murray
Byrd	Harkin	Nelson (FL)
Cantwell	Hollings	Pryor
Carper	Inouye	Reed
Clinton	Johnson	Reid
Conrad	Kennedy	Rockefeller
Corzine	Kohl	Sarbanes
Daschle	Landrieu	Schumer
Dayton	Lautenberg	Stabenow
Dodd	Leahy	Wyden

NOT VOTING—3

Graham (FL)	Kerry	Lieberman

The motion was agreed to.

Mr. GRASSLEY. I move to reconsider the vote.

Mr. SANTORUM. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. Who yields time?

The Senator from Pennsylvania.

Mr. SANTORUM. Mr. President, I ask unanimous consent that the remaining two votes in this series be limited to 10 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 981

The PRESIDING OFFICER. Who yields time on the Pryor amendment?

The Senator from Arkansas.

Mr. PRYOR. I thank the Chair.

Mr. President, the United States may be the only country in the world that does not protect its population from price gouging when it comes to prescription drugs. Last week, the Senate took a very important step in eliminating that by adopting the Dorgan-Cochran amendment by a vote of 62 to 28 to allow the reimportation of prescription drugs from Canada.

This amendment gives that amendment teeth. It gives HHS 2 years to act, and if they do not act within 2 years, then it becomes illegal for prescription drug companies to sell their products in the United States for more than they sell them in Canada.

Some people call this price control. I respectfully disagree, but if you call it price control, that means 62 of us last Friday stood up for price controls. What it does in reality is introduce competition on prices.

There is one drug called tamoxifen. Tamoxifen is a fantastic breast cancer drug. One could buy it before it became generic for $241 for 60 pills in the United States, and for $34 for 60 pills in Canada. The difference between $241 and $34 is very significant, and that is what we are trying to fix.

I thank the Chair.

Mr. SANTORUM. Mr. President, I hope my colleagues can hear me. What the Pryor amendment does has nothing to do with reimportation. What it says is, if the Secretary does not certify that the drugs are safe coming from Canada after 2 years, we will adopt the Canadian pricing scheme for pharmaceutical products in this country. So the Government of Canada will set prices for pharmaceutical drugs in this country. We will be ceding to the Government of Canada the right to set prices for drugs in the United States of America.

If we want to have price controls for drugs, we should have a debate to do that, but we should not be ceding to a foreign government the right to set drug prices in this country, and that is what this amendment does.

Whether you are for reimportation, whether you are for price controls for drugs, do not give up the right to set the price controls to a foreign government who will set them for the United States. And that is what this amendment does. I urge an overwhelming negative vote.

The PRESIDING OFFICER (Mr. CRAPO). The question is on agreeing to the amendment.

Mr. REID. The yeas and nays are not in order.

Mr. SANTORUM. I move to table the amendment and I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The PRESIDING OFFICER. The question is on agreeing to the motion.

The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. REID. I announce that the Senator from Florida (Mr. GRAHAM), the Senator from Massachusetts (Mr. KERRY), and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote ''nay''.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 66, nays 31, as follows:

[Rollcall Vote No. 235 Leg.]

YEAS—66

Alexander	Craig	Lugar
Allard	Crapo	McCain
Allen	DeWine	McConnell
Baucus	Dodd	Mikulski
Bayh	Dole	Murkowski
Bennett	Domenici	Murray
Biden	Ensign	Nelson (NE)
Bingaman	Enzi	Nickles
Bond	Fitzgerald	Roberts
Breaux	Frist	Santorum
Brownback	Graham (SC)	Sessions
Bunning	Grassley	Shelby
Burns	Gregg	Smith
Campbell	Hagel	Snowe
Carper	Hatch	Specter
Chafee	Hollings	Stevens
Chambliss	Hutchison	Sununu
Cochran	Inhofe	Talent
Coleman	Jeffords	Thomas
Collins	Kyl	Voinovich
Cornyn	Landrieu	Warner
Corzine	Lott	Wyden

NAYS—31

Akaka	Feingold	Miller
Boxer	Feinstein	Nelson (FL)
Byrd	Harkin	Pryor
Cantwell	Inouye	Reed
Clinton	Johnson	Reid
Conrad	Kennedy	Rockefeller
Daschle	Kohl	Sarbanes
Dayton	Lautenberg	Schumer
Dorgan	Leahy	Stabenow
Durbin	Levin	
Edwards	Lincoln	

NOT VOTING—3

Graham (FL)	Kerry	Lieberman

The motion was agreed to.

AMENDMENT NO. 1001

The PRESIDING OFFICER. There are 2 minutes equally divided for consideration of the Boxer amendment.

Mrs. BOXER. Mr. President, I would like to explain in 1 minute a very important amendment that will really improve this bill. This amendment is endorsed by the AARP—they feel very strongly about it—in addition to the other major seniors organizations to preserve Social Security and Medicare. In the bill right now, there is a benefit shutdown when you reach $4,500 worth of purchased drugs. That means seniors will face a $1,300 deficit before they start getting the benefit. I will just implore my colleagues, there is not any other prescription drug plan in this country that does this. This is a really terrible problem for our people. Just when they need help the most, they stop getting help.

I conclude, since we have so little time, by reading what AARP says:

> AARP members find the notion of a gap in coverage to be a major barrier to enrolling in a Medicare drug benefit. They tell us that they are unaware of similar features in any of the insurance products they routinely purchase.

In closing, they say:

> . . . we urge the Senate to eliminate this coverage gap.

Please make this bill better, friends. It is the least we can do for seniors.

The PRESIDING OFFICER. The Senator's time has expired.

The Senator from Pennsylvania.

Mr. SANTORUM. Mr. President, I rise in opposition to make four points.

First, we had an additional $30 billion when this bill was originally marked up in the Finance Committee. We put all $30 billion into filling the donut, so we have done as much as we can with the money allocated.

Second, this amendment costs $64 billion. We would bust the agreement, which is to stay within the budget of $400 billion.

Third, according to CMS, only 2 to 12 percent—depending on your estimates—are going to be affected by this ''coverage gap.''

Finally, there is no standard benefit. This is sort of a mystery I don't know why we don't talk about more. This is a typical design of what a benefit would look like. But under this bill, the companies bidding on these pharmaceutical contracts can design the benefit any way they want. They can have a donut. They do not have to have

a donut. The only thing they are required to do is have a $275 deductible for those plans of 160 percent of poverty and above and have $3,700 in total spending before the catastrophic kicks in. The donut is illusory, and I ask my colleagues to vote no on the amendment.

Ms. MIKULSKI. Mr. President, I rise today in strong support of the amendment No. 1001 offered by my colleague from California, Senator BOXER.

The Senate is debating legislation to provide seniors with prescription drugs that is a start but there are also many shortcomings with this bill. One of most glaring shortcomings is the gap in drug coverage. It doesn't make sense. As drug costs rise, benefits get shut off and seniors with high drug costs have to pay all of their drug costs from $4,500 to $5,800. I think that is cruel.

How would this amendment address this shortcoming?

It is simple. This amendment would let seniors continue to have continuous coverage until you hit the catastrophic cap of $5,800 so that means no gap. And, then your copay would drop to 10 percent just like in the bill. No figuring out when you hit the coverage gap. No figuring out how long you are going to be in the hole. No paying premiums and not getting benefits. You simply get drug coverage.

Why is this amendment important?

The coverage gap imposes a ''sickness tax'' on seniors. Once drug spending reaches $4,500 and this is a senior who clearly is facing serious health problems this senior would now have to pay $1,300 of their own money without any help from the Government even though they are still paying premiums to stay in the plan.

What does this mean?

Millions of our seniors will have no drug coverage for several months out the year. Their coverage will just stop and for many; it may not start back up again until the next year.

This is wrong. I believe honor thy mother and father is not just a good commandment to live by, it is good public policy to govern by. That is why I feel so strongly about Medicare. Congress created Medicare to provide a safety net for seniors. I don't think there should be any holes in that net. That is why I support this amendment and urge my colleagues to also.

The PRESIDING OFFICER. The Senator's time has expired.

The yeas and nays have been previously ordered on this amendment.

Mr. SANTORUM. Mr. President, I move to table the amendment and ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to the motion to table amendment No. 1001.

The clerk will call the roll.

The legislative clerk called the roll.

Mr. MCCONNELL. I announce that the Senator from Colorado (Mr. CAMPBELL) is necessarily absent.

Mr. REID. I announce that the Senator from Florida (Mr. GRAHAM), the Senator from Massachusetts (Mr. KERRY), and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Florida (Mr. GRAHAM) and the Senator from Massachusetts (Mr. KERRY) would each vote ''nay''.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 54, nays 42, as follows:

[Rollcall Vote No. 236 Leg.]

YEAS—54

Alexander	DeWine	McCain
Allard	Dole	McConnell
Allen	Domenici	Miller
Baucus	Ensign	Murkowski
Bennett	Enzi	Nickles
Bond	Fitzgerald	Roberts
Breaux	Frist	Santorum
Brownback	Graham (SC)	Sessions
Bunning	Grassley	Shelby
Burns	Gregg	Smith
Chafee	Hagel	Snowe
Chambliss	Hatch	Specter
Cochran	Hutchison	Stevens
Coleman	Inhofe	Sununu
Collins	Jeffords	Talent
Cornyn	Kyl	Thomas
Craig	Lott	Voinovich
Crapo	Lugar	Warner

NAYS—42

Akaka	Dorgan	Levin
Bayh	Durbin	Lincoln
Biden	Edwards	Mikulski
Bingaman	Feingold	Murray
Boxer	Feinstein	Nelson (FL)
Byrd	Harkin	Nelson (NE)
Cantwell	Hollings	Pryor
Carper	Inouye	Reed
Clinton	Johnson	Reid
Conrad	Kennedy	Rockefeller
Corzine	Kohl	Sarbanes
Daschle	Landrieu	Schumer
Dayton	Lautenberg	Stabenow
Dodd	Leahy	Wyden

NOT VOTING—4

Campbell	Kerry
Graham (FL)	Lieberman

The motion was agreed to.

Mr. GRASSLEY. I move to reconsider the vote, and I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. BAUCUS. Mr. President, I ask unanimous consent that all pending amendments be laid aside so that the Senator from New Jersey may offer an amendment.

The PRESIDING OFFICER. Is there objection?

Mr. SESSIONS. Reserving the right to object, is the Senator going to speak? I could not hear.

Mr. BAUCUS. I withdraw the request. I ask unanimous consent that there be 30 minutes equally divided on the Lautenberg amendment and, immediately following that debate, the Senate vote on the Lautenberg amendment.

Mr. SESSIONS. Reserving the right to object, I just want to call up an amendment and set it aside. Will the Senator agree we can do that?

Mr. LAUTENBERG. I did not hear the request. Was the Senator asking a question of me?

Mr. SESSIONS. Mr. President, I was asking unanimous consent that I be allowed to call up an amendment for 30 seconds and set it aside before the Senator from New Jersey commences his remarks.

The PRESIDING OFFICER. The Senator from Montana has the floor.

Mr. BAUCUS. I yield the floor and withdraw my request.

The PRESIDING OFFICER. The Senator from Alabama may state his request.

AMENDMENT NO. 1011

Mr. SESSIONS. Mr. President, I call up amendment No. 1011.

The PRESIDING OFFICER. The Chair will interpret the Senator's request as a unanimous consent request to set aside all pending amendments. Is there objection to setting aside all pending amendments?

Without objection, it is so ordered. The clerk will report.

The legislative clerk read as follows:

The Senator from Alabama [Mr. SESSIONS] proposes an amendment numbered 1011.

Mr. SESSIONS. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To express the sense of the Senate that the Committee on Finance should hold hearings regarding permitting States to provide health benefits to legal immigrants under medicaid and SCHIP as part of the reauthorization of the temporary assistance for needy families program)

Strike section 605 and insert the following:

SEC. 605. SENSE OF THE SENATE REGARDING HEALTH INSURANCE COVERAGE OF LEGAL IMMIGRANTS UNDER MEDICAID AND SCHIP.

(a) FINDINGS.—The Senate makes the following findings:

(1) In 1996, in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2105)(commonly referred to as the ''welfare reform Act''), Congress deliberately limited the Federal public benefits available to legal immigrants.

(2) The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 allows a State the option of electing to offer permanent resident legal aliens that have been living in the United States for at least 5 years the same benefits that their State citizens receive under the temporary assistance for needy families program (commonly referred to as ''TANF'') and the medicaid program.

(3) As of the date of enactment of this Act, 22 States have elected to give the permanent resident legal aliens who reside in their States the same TANF and medicaid benefits as the States provide to the citizens of their States.

(4) This Act, the Prescription Drug and Medicare Improvement Act of 2003, is not a welfare or medicaid reform bill, but rather is a package of improvements for the medicare program that is designed to provide greater access to health care for America's seniors.

(5) The section heading for 605 of this Act as reported out of the Committee on Finance, was titled ''Assistance with Coverage of Legal Immigrants under the medicaid program and SCHIP,'' and, as reported, related directly to the provision of benefits under

the medicaid and State children's health insurance programs, not to benefits provided under the medicare program.

(6) The reported version of section 605 would have directly overturned the reforms made in the 1996 welfare reform Act.

(7) The reported version of section 605 would have greatly expanded the number of individuals who could receive benefits under medicaid and SCHIP.

(8) No hearings have been held in the Committee on Finance of the Senate concerning why the 5-year residency requirement for legal aliens to obtain a Federal public benefit established in the welfare reform Act needs to be overturned or why the reported version of section 605 should be included in a medicare reform package.

(9) Congress must reauthorize the temporary assistance for needy families program later this year and should hold hearings regarding whether the 5-year residency requirement for legal aliens to obtain a Federal public benefit should be overturned as part of the reauthorization of that program.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that the Committee on Finance of the Senate should hold hearings in connection with the reauthorization of the temporary assistance for needy families program, or in connection with reform of the medicaid program, regarding whether the 5-year residency requirement for legal aliens to obtain a Federal public benefit that was established in the 1996 welfare reform Act should be overturned for purposes of the medicaid and State children's health insurance programs.

Mr. SESSIONS. Mr. President, I ask unanimous consent that the amendment be set aside for consideration at the appropriate time.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. SESSIONS. I yield the floor.

The PRESIDING OFFICER. The Senator from New Jersey.

Mr. LAUTENBERG. Mr. President, I want to be certain of the order. My amendment is at the desk. What I want to do is in the time allocated to me—which I understand is 15 minutes per side; is that correct?

The PRESIDING OFFICER. At this point, no such order has been entered.

Mr. LAUTENBERG. I thank the Chair.

AMENDMENT NO. 982

Mr. LAUTENBERG. Mr. President, I call up my amendment which is at the desk.

The PRESIDING OFFICER. Without objection, the pending amendments will be set aside. The clerk will report.

The legislative clerk read as follows:

The Senator from New Jersey [Mr. LAUTENBERG], for himself, Mr. REED, Mr. REID, Mrs. CLINTON, and Mr. CORZINE, proposes an amendment numbered 982.

Mr. LAUTENBERG. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To make prescription drug coverage available beginning on July 1, 2004)

At the end of title I, insert the following:

SEC. ___. IMPLEMENTATION OF TITLE.

Notwithstanding any other provision of this Act, the amendments made by this title shall be implemented and administered so that prescription drug coverage is first provided under part D of title XVIII beginning on July 1, 2004.

Mr. LAUTENBERG. Mr. President, I rise to talk about my amendment which is designed to change the effective date of this bill.

My amendment is cosponsored by Senators REED of Rhode Island, REID of Nevada, CLINTON, and CORZINE.

My amendment is very simple: Let's give our seniors a prescription drug benefit just as quickly as we can. They need it now. Let's not delay any longer than practicable to get it into place.

Under the current proposal, comprehensive drug coverage does not start until July 2006. Imagine that, 2006. It is not fair to seniors who are expecting a benefit almost immediately. They will have seen President Bush sign a bill with some fanfare and will have seen lots of Members of Congress crowding the stage with him, and everyone will say: We have put a prescription drug benefit into place. When seniors learn that the benefit begins in 2006, they are going to feel deceived, tricked, and angry.

My amendment changes the effective date of the coverage to July 1, 2004. There is not any reason to have our seniors wait any longer for a prescription drug benefit.

The original Medicare plan was signed into law by President Johnson on July 30, 1965, and 11 months later, July 1, 1966, all persons eligible were enrolled. The entire system for Medicare was created in just 11 months.

When we look at this chart, we see what is planned with the Bush/Senate prescription drug benefit. We are looking at 30 months, and we are looking at the creation of an entire Medicare system which took just 11 months to put in place. That was done without the luxury of today's high-speed computers. It was just President Johnson and his administration getting the entire system in place in 11 months.

My amendment essentially follows the same timetable. If President Johnson was able to create the entire Medicare system in just 11 months, then surely President Bush should be able to add a drug benefit in the same amount of time.

Look at the timeline the President has set for this Medicare drug proposal: 30 months. Why so long? Our clue is, what? Election day. That is illustrated on this chart. Sixteen months from now, this prolonged effective date is conveniently well past election day.

The administration's Medicare agency, CMS, says it needs 30 months. That is very convenient timing for political purposes, but it is terrible timing for America's seniors.

President Johnson, a true Texan, had a can-do attitude, and there is no reason this administration cannot dedicate itself to completing this task in 11 months. We need to give seniors meaningful drug coverage as soon as possible, not 2006.

The reality is that 5.5 million seniors currently on Medicare will not be alive in 2006. If there are insufficient funds in the budget for this amendment, then it is the result of choices made by the President and his party. They chose to provide a massive tax cut to the wealthiest among us, and they chose it at the price of Medicare.

The issue is simple: If we give a prescription drug benefit, why would we want to withhold it? This bill is about fooling the American people about the mission here. It is more about elections than correcting the problems associated with a prescription drug program. I urge my colleagues to support this amendment.

Mr. President, we have some time remaining. How much time remains on our side?

The PRESIDING OFFICER. There is no set amount of time. The Senator has consumed 5 minutes.

Mr. LAUTENBERG. Mr. President, I yield the floor. I know the Senator from Nevada is interested in speaking.

Mr. GRASSLEY. Mr. President, I yield myself such time as I may consume in opposition to the Lautenberg amendment.

The PRESIDING OFFICER. The Senator has the floor.

Mr. GRASSLEY. Maybe I should ask, are we under time constraints?

The PRESIDING OFFICER. There are no time constraints.

Mr. GRASSLEY. What the Senator from New Jersey wants to do I wish we could do. I personally was somewhat astounded when we asked experts at the Congressional Budget Office, experts at the Office of Management and Budget, experts in the Department of Health and Human Services, how much time it would take to get this new prescription drug program underway. We were advised to start it in the year 2006.

In an ideal world, all seniors would have access to our comprehensive prescription drug benefit next year. But our plan, I am sorry to say, cannot go into effect until 2006. Therefore, we need to do something to help our seniors right now. Part of S. 1 does that. They have been doing it because seniors, as I am sure the Senator from New Jersey is trying to respond to, have been waiting a very long time for Congress to act and pass a prescription drug benefit, in the end, helping them with the tremendous costs they are paying for prescription drugs.

This obviously is not satisfying to the Senator from New Jersey who would like to get this plan underway much sooner. Because of the waiting period until the year 2006 to get the very comprehensive program underway, we included in our plan a temporary prescription drug discount card. This is a voluntary program that all seniors can partake of next year. It is available for an annual fee costing no more than $25. Since our low-income seniors need extra help, this fee would be waived. It provides for a 10-percent

to 25-percent discount on all costs of prescription drugs. There are some seniors for whom even a 10-percent to 25-percent discount is still a hardship to purchase prescription drugs. So we have added to this for really low-income seniors to receive a $600 annual help in purchasing prescription drugs during this interim period of time, 2004 and 2005. They will be required to pay a minimal copayment of 10 percent when the spending of the $600 subsidy is in place. Spouses who receive the low-income benefit are also allowed to pool share their deposits.

When the comprehensive drug program begins January 1, 2006, the discount card program automatically ends. However, low-income seniors will be able to use their allotment of $600 until June 2006.

Almost 10 million Medicare beneficiaries with significant prescription drug needs will realize savings from this endorsement program. The Center for Medicare Services projects that the Medicare beneficiaries will save between $1.2 billion and $1.6 billion in the program the very first year.

As I said, I feel, not for reasons I like to give to my fellow Senators, that we cannot expect this comprehensive new prescription drug program for seniors, which happens to be the first major improvement in strengthening of Medicare since 1965, to go into effect. Maybe we can push and push and push, but this first major expansion of Medicare in 38 years ought to be carefully done and done right. Consequently, that is why we have deferred to the judgment of the Congressional Budget Office, Office of Management and Budget, as well as the Secretary of HHS. We have tried to compensate for the long period of phasing with the discount card and the $600 subsidy.

I wish I could do more. I wish I could vote for the Senator's amendment but I cannot. I ask my colleagues to vote against it.

I yield the floor.

The PRESIDING OFFICER. The Senator from New Jersey.

Mr. LAUTENBERG. I say to our friend from Iowa, the discount card allows somewhere between 10 and up to 25 percent. With seniors spending an average $2,300 a year on medication, even a 20-percent discount does not provide nearly enough relief. Frankly, it is hard to understand why it has to take 2½ years to get the program into place. I rather suspect it has less to do with the perfection of the program than it has to do with some other cause. It cannot take that long. We have all of these seniors on record. They are medical enrollees now. Why can't we get this going?

As a matter of fact, my colleague from Minnesota, who is going to say something, thinks it should be done in an even shorter period of time than my amendment provides.

I ask my colleague if he would like to say something. I yield the floor.

The PRESIDING OFFICER. The Senator from Minnesota.

Mr. DAYTON. Mr. President, I join with my Senator from New Jersey. He persuaded me to be reasonable. This is the reasonable alternative proposal, July 1 of 2004. I have great respect for the chairman of the Senate Finance Committee, the Senator from Iowa. I sense his difficulty because I don't believe the senior citizens of anywhere else in America will be any different from the senior citizens of Minnesota who will be, I believe, absolutely beside themselves to learn this program they have waited years for Congress to enact will be enacted but it will not be ready for 2½ years.

I suggest perhaps one of the reasons is that this is not a system that can be easily put in place or administered. The chairman is trying to accommodate, if I understand his remarks correctly, the administration, the Office of Management and Budget, and the Secretary of Health and Human Services. They said this program as designed cannot be put together and administered and operational until January 1, 2006.

I suggest that is pretty strong evidence that is not a very good system for delivery of these services. We have insurance companies that are going to be providing policies—they are in the business of providing insurance for people. It can't take them 2½ years to design this program. Regarding CMS or HHS, the Department itself, we hear from this administration how their management of Government is so much improved over their predecessor's. Is it going to take them 2½ years to design this program when, as my colleague from New Jersey, Senator LAUTENBERG, pointed out, 40 years ago they were able to take the whole Medicare Program and put that in effect in 11 months?

Not only do I support the amendment offered by Senator LAUTENBERG, but I have to say for those who are advocating this as the preferred alternative to extending Medicare to cover prescription drugs, if they cannot get the program up and running in a lot less than 2½ years—either 6 months as I would propose, or a year—then this is the wrong program because this is not a viable alternative, and it is not viable for the senior citizens of Minnesota or anywhere else, in my judgment.

To say people are going to get a discount card—they can get discount cards already. They don't need Congress to do anything more than that for 2½ years.

Just taking the figure the Senator from Iowa offered, if I understand it correctly, of savings for seniors in America, Medicare beneficiaries, of $1.26 billion the first year, it sounds like a lot of money—it is a lot of money—but there are 40 million Medicare beneficiaries in the country. If you divide $1.26 billion in savings by those 40 million, that is about $30 per Medicare beneficiary in the first year.

We are going to go back with this to the senior citizens of Minnesota, and those with disabilities who are being crushed by these prices, who see them going up all the time due to the greed and profiteering of the pharmaceutical industry. We are told here we have a bill, because it is the only one the majority of the Senate will agree to, that is not going to do anything—nothing at all, under our Government, on behalf of seniors and on behalf of all American consumers of prescription drugs, to bring these prices down. Instead, they are going to get a discount card that is going to save them on average $30 a year? We ought to be ashamed of ourselves, first of all. This bill is not what it is purporting to be, which is real relief for anybody who needs it now, not January 1, 2006.

If my colleagues do not support this, I think we are sending a very strong message to America that this is not a viable program to begin with, and the pharmaceutical industry has, one more time, succeeded in putting their profits ahead of the needs of people in America.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. I know the Senator from New Hampshire would like to go ahead. I will speak for just a minute or 2 before he does.

I very much agree with the Senator. It seems absurd that we have to wait until 2006 before this program goes into effect. I very much understand the concern of the Senator.

Let me say this to all of us who are concerned. Before the conference report comes back, I am going to do my level best by pushing the CBO and CMS, asking a lot of tough questions of these agencies, to see if there is some way we can get this put together earlier. It is my hope we could bring back a conference report that has an earlier date, significantly earlier date. My guess is the private sector could get this done pretty quickly. It would not take a full 2 years to get it done.

I just pledge to my colleagues, this is one Senator who is going to do his level best to try to get an earlier date. The current date just doesn't make sense. We need to ask some tough questions and get some answers.

I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. If the Senator from New Hampshire will just give me a minute, I have a unanimous consent request on votes coming up I would like to propound.

I ask unanimous consent that at 4:20 the Senate proceed to a vote in relation to Dayton amendment No. 957, to be followed by a vote in relation to the Lincoln amendment, No. 1002; to be followed by a vote in relation to the Lautenberg amendment, No. 982, with 2 minutes equally divided for debate for each succeeding vote after the first; further, that no amendments be in order to the amendments prior to the votes; and finally that the second and

third votes be limited to 10 minutes in length.

I ask unanimous consent that prior to the first vote, Senator SUNUNU be recognized for up to 5 minutes in order to offer an amendment.

Mr. REID. Reserving the right to object, I ask the vote occur at 4:25 and I be given 5 minutes after Senator SUNUNU.

Mr. GRASSLEY. I modify my unanimous consent request accordingly.

The PRESIDING OFFICER. Is there objection?

Mr. DAYTON. Reserving the right to object, I ask the Senator, in terms of the motion, that 2 minutes be evenly divided for my amendment, the first amendment. Is there something different for that?

Mr. GRASSLEY. You would have 1 minute and I would have 1 minute.

Mr. DAYTON. I object to that. I was told by the Senator's staff I would have 2 minutes, 4 minutes equally divided.

Mr. REID. He can take a minute of my time.

Mr. GRASSLEY. You will get 2 minutes, one from your leader. Can we go ahead?

Mr. DAYTON. I have no objection.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

The Senator from New Hampshire.

AMENDMENT NO. 1010

(Purpose: To improve outpatient vision services under part B of the medicare program.)

Mr. SUNUNU. Mr. President, I ask unanimous consent that all pending amendments be set aside for purposes of offering an amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. SUNUNU. Mr. President, I have an amendment at the desk. I ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from New Hampshire [Mr. SUNUNU] proposes an amendment numbered 1010.

Mr. SUNUNU. I ask unanimous consent the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

(The amendment is printed in today's RECORD under ''Text of Amendments.'')

Mr. SUNUNU. Mr. President, I rise to offer an amendment that effectively mirrors a piece of legislation I introduced earlier this year. This amendment will extend benefits under Medicare for vision rehabilitative services; that is, rehabilitative services for those seniors with a vision impairment.

As we debate this important prescription drug legislation, I think one of the cornerstones, one of the principles that is at stake is the objective of giving seniors more options and more choices for their health care and, in doing so, to create an option for a more holistic approach to their health care that perhaps focuses, to a greater extent, on preventive measures and other services that improve independence and improve a senior's quality of life.

This legislation is very much in keeping with that objective and that goal. This will extend coverage for vision rehabilitative services under Medicare, but it does this under the existing physician fee schedule. It does it without creating a new provider network or a new fee schedule. As a result, the cost of this legislation is estimated, over a 5-year period, to be just $8 million. That was an independent estimate that has been done. Of course, I will seek scoring under the Congressional Budget Office for the purpose of this bill.

It is legislation and a set of services that is geared toward improving the level of independence and quality of life for those seniors who are affected by a vision impairment. For the sake of reference, there are over 3.5 million Americans who are affected by vision impairment in the United States. That means vision loss that cannot be treated with eye glasses, that cannot be treated with surgery or other techniques. These seniors need help in learning how to navigate in their own homes, how to deal with the obstacles of daily life, and how to learn to live and work with that vision impairment.

The cost of vision impairment to America and to our seniors can be huge. The CDC estimates over $20 billion in costs annually due to falls and due to injuries that have occurred as a result of vision loss. Hip fractures alone, due to vision loss, are estimated to cost our country over $2 billion per year.

For those reasons, I envision under this legislation cost savings in the long term to be quite significant for the modest cost of improving coverage for these vision rehabilitative services.

This is a piece of legislation I introduced earlier this year for which I was pleased to receive bipartisan support. We have 14 cosponsors—seven Republicans, seven Democrats—and among them a number of the members of the Finance Committee.

I certainly believe this takes the right approach toward strengthening Medicare in a way that gives more focus to the kind of preventive care and the kind of medical maintenance that improves the independence and quality of life for our seniors.

I urge my colleagues to support the amendment.

I yield the floor.

The PRESIDING OFFICER. The Democratic whip is recognized.

Mr. REID. Mr. President, under the consent we obtained, I was to have 5 minutes to speak. I would ask that 1 minute of that time be given to Senator DAYTON, so he can have his 2 minutes. I ask the Chair to notify me when I have used 3 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 982

Mr. REID. Mr. President, my first elective job was when Medicare came into being. I was the chairman of the board of trustees at a place called Southern Nevada Memorial Hospital. It is now called the University Medical Center. At that time it was the largest medical facility, hospital facility in Nevada.

At that time 40 percent of the seniors who came into that hospital had no insurance, and children, other relatives, and friends had to sign a piece of paper before they came into the hospital that they would be responsible for the bills. Medicare changed all that.

In 1965, when Medicare was created by Congress, it took 11 months after the bill was signed to put a new program in place. That was back in the days of slide rules and adding machines. That was, of course, before we had computers that had any ability to function.

Today our senior citizens need help with soaring drug prices. They deserve the security of knowing they will be able to buy the medicines that can keep them alive and healthy.

So today if we are telling our seniors to wait for that help and that security until the year 2006, I do not think they are going to accept that. It will be too late for millions of seniors, people who have worked hard all their lives to make this the greatest and richest country in the world—the only superpower left in the world. Certainly, if that, in fact, is the case, we should have a prescription drug benefit for senior citizens.

It might be too late for Alice and Frederick Williams of Reno. They worked hard all their lives and raised four children. But Alice contracted hepatitis C from a blood transfusion. Today she is also battling heart disease and a thyroid condition, and Frederick is recovering from prostate cancer. Together, they have to spend $350 every month on prescription drugs. That is $4,200 a year. They don't have it.

Jackie Ridley, it might be too late for her. She is a retired teacher, who spoke at a Committee on Aging hearing in Las Vegas. She and her husband had all kinds of problems: heart disease, high blood pressure, diabetes, and emphysema. Between them, they had 25 prescriptions. Before Jackie's husband passed away, they faced out-of-pocket expenses of more than $1,000 every month. And sometimes, to make it to the next month, they cut back on some of their medicine. We have heard that before.

These Nevada seniors, and millions more like them in every single State, need help now, not 3 years from now. They deserve security now, not in 2006. That is why I rise to support the Lautenberg amendment. It would make this prescription drug benefit effective sooner rather than later.

The bill is confusing enough without asking some senior citizens to apply for one benefit now, and then come

back in 2 years to apply again. Our seniors have enough to worry about without wondering if they will be ruined financially before the benefit takes effect.

The American people know that when Congress really wants to get things done, we can take action quickly. Now they are looking for us to help them, seniors who have worked hard to make this country strong and prosperous.

I urge the support of the Lautenberg amendment.

I yield back whatever time I have.

The PRESIDING OFFICER. The Senator has used 3 minutes.

Mr. REID. I yield back.

The PRESIDING OFFICER. The Senator from Minnesota.

AMENDMENT NO. 957

Mr. DAYTON. Mr. President, I understand, under the previous order, I have 2 minutes.

The PRESIDING OFFICER. The Senator has 2 minutes.

Mr. DAYTON. Mr. President, I call up amendment No. 957 and ask the clerk to report it.

The PRESIDING OFFICER. The amendment is pending.

Mr. DAYTON. Thank you, Mr. President. I will proceed.

Mr. President, this amendment is a matter of simple fairness. It says that whatever prescription drug coverage we in Congress vote for for senior citizens and other Medicare beneficiaries in this legislation, then the Members of Congress will get for ourselves, our coverage, under prescription drugs for the life of this particular legislation.

I have heard many of my colleagues say we want to give seniors coverage that is as good as we get ourselves. I heard a lot of senior citizens in Minnesota say they want coverage as good as Members of Congress get for themselves. Well, unfortunately, the bill that is before us this week is not even close to that parity.

If you calculate the total benefits provided, the value of this bill is about half of what Members of Congress get, what we pay as part of the Federal Employees Health Benefits Plan system. But, nevertheless, it is about twice as good as what the seniors of America and those with disabilities and others are going to be able to obtain from what we are likely to pass.

Furthermore, as we have been discussing earlier, this does not even begin until January of 2006. Medicare beneficiaries will get a discount card instead. Well, then, Members of Congress should get a discount card—and nothing more—as well. I think after what I heard the Senator from Iowa say, I would include a few members of the administration since they are the culprits in this delay, but I will save that for another time. With the premiums, deductibles, and the absence of any coverage at all from $4,500 to $5,800, if it is good enough for the seniors of America, then it is good enough for the Members of Congress.

I point out to my colleagues who would like to keep the benefit level they have today——

The PRESIDING OFFICER. The Senator has used 2 minutes.

Mr. DAYTON. Mr. President, I ask unanimous consent for 30 seconds to conclude my remarks.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. DAYTON. The amendment Senator DURBIN has offered, which we will have a chance to vote on and discuss later this week, would provide seniors with a comparable package to what we have in Congress. So I urge the support of that amendment, for that reason among many others. But if we are not going to be as generous to senior citizens as we are to ourselves today, then we are going to have to, in my view, bring ourselves down. I would rather bring everyone else up, but what is fair for them is fair for us.

I thank the Chair. I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. I yield back my time and wish to vote now.

I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be.

The question is on agreeing to amendment No. 957.

The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. MCCONNELL. I announce that the Senator from Colorado (Mr. CAMPBELL) is necessarily absent.

Mr. REID. I announce that the Senator from Florida (Mr. GRAHAM), the Senator from Massachusetts (Mr. KERRY), and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.,

I further announce that, if present and voting, the Senator from Florida (Mr. GRAHAM) and the Senator from Massachusetts (Mr. KERRY) would each vote ''yea''.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 93, nays 3, as follows:

[Rollcall Vote No. 237 Leg.]

YEAS—93

Akaka	Collins	Graham (SC)
Alexander	Conrad	Grassley
Allard	Cornyn	Gregg
Allen	Corzine	Hagel
Baucus	Craig	Harkin
Bayh	Crapo	Hatch
Bennett	Daschle	Hutchison
Biden	Dayton	Inhofe
Bond	DeWine	Inouye
Boxer	Dodd	Jeffords
Brownback	Dole	Johnson
Bunning	Domenici	Kennedy
Burns	Dorgan	Kohl
Byrd	Durbin	Kyl
Cantwell	Edwards	Landrieu
Carper	Ensign	Lautenberg
Chafee	Enzi	Leahy
Chambliss	Feingold	Levin
Clinton	Feinstein	Lincoln
Cochran	Fitzgerald	Lott
Coleman	Frist	Lugar
McCain	Reed	Snowe
McConnell	Reid	Specter
Mikulski	Roberts	Stabenow
Miller	Rockefeller	Stevens
Murkowski	Santorum	Sununu
Murray	Sarbanes	Talent
Nelson (FL)	Schumer	Thomas
Nelson (NE)	Sessions	Voinovich
Nickles	Shelby	Warner
Pryor	Smith	Wyden

NAYS—3

Bingaman	Breaux	Hollings

NOT VOTING—4

Campbell	Kerry
Graham (FL)	Lieberman

The amendment (No. 957) was agreed to.

AMENDMENT NO. 1002

The PRESIDING OFFICER. Under the previous order, there are 2 minutes equally divided prior to the vote on the Lincoln amendment.

The PRESIDING OFFICER. Who yields time?

The Senator from Arkansas. The Senator has 1 minute.

Mrs. LINCOLN. Mr. President, I plead with my colleagues to take a very serious look at the amendment before us. I know they are hearing differently from downtown perhaps, but I want them to take a look at a recent CBO study that has indicated to us there is negligible impact in giving parity to the fallback plan.

CBO has given us a recent study that indicates there is negligible impact on the private plans in allowing parity with the fallback plans that may be needed in some of our rural areas to ensure that all of our citizens across this great land get the same benefit in a prescription drug package.

Fifteen of our States have no Medicare+Choice or private plans currently. We know it is going to be difficult. Let's make sure a fallback plan is there for seniors, that the continuity is there for them. All we want to do is make sure they will have the same 2-year contract cycle that the private plans will have.

Again, approximately 80 percent of the people in this country are in fee-for-service plans. Let's make sure those who are in our rural States are going to see the parity in these two plans. Just remember, if the private plans are not there or happen to be there, there will be no fallback plan, so you do not have any problem with that.

I thank the Chair.

The PRESIDING OFFICER. The Senator's time has expired.

Mrs. LINCOLN. I encourage my colleagues to vote for this amendment.

The PRESIDING OFFICER. Who yields time?

The Senator from Pennsylvania.

Mr. SANTORUM. Mr. President, I oppose the amendment. First off, it is bad enough to have one fallback, which I believe will dramatically discourage private plans from participating in a stand-alone drug benefit. To have two is even worse.

The fact is, the Secretary has the authority under this legislation to balance the risk. With a fallback plan,

there is no risk on the private sector. All the risk for a plan is on the public sector. We give the Secretary the ability to dial back the risk to everything but zero, and the fallback plan is zero. We believe giving the Secretary the discretion will at least encourage the private sector to come in, which they will under this bill, and take some risk, which means they will have some incentive to control costs. If they have no risk, they have no incentive and, thereby, the cost of the program goes up.

Having one fallback plan is a very bad idea. Expanding this very bad idea is a worse idea, and I hope we vote against the amendment.

I ask unanimous consent that the remaining two votes in this series be limited to 10 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. SANTORUM. Mr. President, I move to table the amendment and ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The question is on agreeing to the motion.

The clerk will call the roll.

The legislative clerk called the roll.

Mr. MCCONNELL. I announce that the Senator from Colorado (Mr. CAMPBELL) is necessarily absent.

Mr. REID. I announce that the Senator from Florida (Mr. GRAHAM), the Senator from Massachusetts (Mr. KERRY), and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Florida (Mr. GRAHAM) and the Senator from Massachusetts (Mr. KERRY) would each vote ''no''.

The PRESIDING OFFICER (Mrs. DOLE). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 51, nays 45, as follows:

[Rollcall Vote No. 238 Leg.]

YEAS—51

Alexander	Dole	McCain
Allard	Domenici	McConnell
Allen	Ensign	Murkowski
Baucus	Enzi	Nickles
Bennett	Fitzgerald	Roberts
Bond	Frist	Santorum
Breaux	Graham (SC)	Sessions
Brownback	Grassley	Shelby
Bunning	Gregg	Smith
Burns	Hagel	Snowe
Chambliss	Hatch	Specter
Cochran	Hutchison	Stevens
Coleman	Inhofe	Sununu
Cornyn	Jeffords	Talent
Craig	Kyl	Thomas
Crapo	Lott	Voinovich
DeWine	Lugar	Warner

NAYS—45

Akaka	Clinton	Edwards
Bayh	Collins	Feingold
Biden	Conrad	Feinstein
Bingaman	Corzine	Harkin
Boxer	Daschle	Hollings
Byrd	Dayton	Inouye
Cantwell	Dodd	Johnson
Carper	Dorgan	Kennedy
Chafee	Durbin	Kohl
Landrieu	Miller	Reid
Lautenberg	Murray	Rockefeller
Leahy	Nelson (FL)	Sarbanes
Levin	Nelson (NE)	Schumer
Lincoln	Pryor	Stabenow
Mikulski	Reed	Wyden

NOT VOTING—4

Campbell	Kerry
Graham (FL)	Lieberman

The motion was agreed to.

Mr. GRASSLEY. I move to reconsider the vote.

Mr. BAUCUS. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 982

The PRESIDING OFFICER. Under the previous order, there are now 2 minutes for debate prior to a vote in relation to the Lautenberg amendment, No. 982.

Who yields time?

The Senator from New Jersey.

Mr. LAUTENBERG. Madam President, my amendment is very simple. It says, if you are going to give, then don't take it away. If you are going to give a prescription drug benefit, then, by golly, start it in a timely manner, and start it, let's say, by July of 2004 instead of 2006.

What kind of a benefit is this when 5.5 million of our present living seniors, I am sorry to say, will not be here at that time, 30 months hence. In 11 months, President Lyndon Johnson initiated the idea of Medicare and had it passed and in place—11 months. Why in the world is it going to take 30 months?

I do not believe we ought to be looking at these discount cards, which are available generally in the community today, as the stopover until 30 months have gone by. It is an outrage that this date is chosen, I think not because they want to delay the benefit for seniors but, rather, because it coincides with an election. I do not think we ought to stand for it.

The PRESIDING OFFICER. The Senator's time has expired.

The Senator from Iowa.

Mr. GRASSLEY. Madam President, I sympathize with those who feel a need to get this program going sooner than we have it in this legislation. But the fact is, CMS has told us it is physically impossible to get this benefit up and running in the year 2004. Now, knowing that, we have provided a prescription drug discount card, starting on January 1, 2004, in order to get immediate relief from the high cost of prescriptions for our seniors.

The amendment would spend close to $24 billion in fiscal year 2004—the amendment that is before us—and that is money that is not in the budget. We deal with the needs of our seniors in a fair way with this bill, the discount card, and the $600 help for them for each of the next 2 years. So I urge my colleagues to take all this into consideration and oppose the amendment.

Madam President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The question is on agreeing to amendment No. 982.

The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. MCCONNELL. I announce that the Senator from Kansas (Mr. BROWNBACK) and the Senator from Colorado (Mr. CAMPBELL) are necessarily absent.

I further announce that if present and voting the Senator from Kansas (Mr. BROWNBACK) would vote ''no''.

Mr. REID. I announce that the Senator from Florida (Mr. GRAHAM), the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote ''yea''.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 41, nays 54, as follows:

[Rollcall Vote No. 239 Leg.]

YEAS—41

Akaka	Dorgan	Lincoln
Bayh	Durbin	Mikulski
Biden	Edwards	Murray
Bingaman	Feingold	Nelson (FL)
Boxer	Feinstein	Pryor
Byrd	Harkin	Reed
Cantwell	Hollings	Reid
Carper	Inouye	Rockefeller
Clinton	Johnson	Sarbanes
Conrad	Kennedy	Schumer
Corzine	Kohl	Stabenow
Daschle	Lautenberg	Talent
Dayton	Leahy	Wyden
Dodd	Levin	

NAYS—54

Alexander	Dole	McCain
Allard	Domenici	McConnell
Allen	Ensign	Miller
Baucus	Enzi	Murkowski
Bennett	Fitzgerald	Nelson (NE)
Bond	Frist	Nickles
Breaux	Graham (SC)	Roberts
Bunning	Grassley	Santorum
Burns	Gregg	Sessions
Chafee	Hagel	Shelby
Chambliss	Hatch	Smith
Cochran	Hutchison	Snowe
Coleman	Inhofe	Specter
Collins	Jeffords	Stevens
Cornyn	Kyl	Sununu
Craig	Landrieu	Thomas
Crapo	Lott	Voinovich
DeWine	Lugar	Warner

NOT VOTING—5

Brownback	Graham (FL)	Lieberman
Campbell	Kerry	

The amendment (No. 982) was rejected.

Mr. GRASSLEY. Madam President, I move to reconsider the vote.

Mr. REID. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. REID. Madam President, the two leaders have met and talked to the managers. We will have, in approximately 30 minutes, two votes. Senator DODD has agreed to take 20 minutes on his two amendments. He can divide it however he deems appropriate. Following that, the Senate will still be in

session. People will offer amendments, if they desire, but it is contemplated these two votes will be the last votes of the evening.

The PRESIDING OFFICER. The Senator from Connecticut is recognized.

Mr. DODD. Madam President, I ask unanimous consent that the pending amendment be temporarily laid aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 998

Mr. DODD. Madam President, I call up amendment No. 998.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Connecticut [Mr. DODD] proposes an amendment numbered 998.

Mr. DODD. Madam President, I ask unanimous consent that further reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To modify the amount of the direct subsidy to be provided to qualified retiree prescription drug plans)

On page 129, strike lines 3 through 20, and insert the following:

''(2) AMOUNT OF PAYMENT.—The amount of the payment under paragraph (1) shall be an amount equal to the monthly national average premium for the year (determined under section 1860D–15), as adjusted using the risk adjusters that apply to the standard prescription drug coverage published under section 1860D–11.

Mr. DODD. Madam President, this first amendment is intended to address one of the major problems with this bill, and that is the impact the legislation could have on Medicare beneficiaries who are currently receiving prescription drug coverage under the employer-sponsored retiree benefit plans.

I will quickly point out to my colleagues who may be saying we voted on this with the Rockefeller amendment that this is very different. The Rockefeller amendment was designed to provide encouragement to employers to supplement the existing prescription drug benefit. This amendment is designed to provide that encouragement only to employers who would be picking up the total cost of the prescription drug benefit, not just acting as a supplement. So it is very different. It is not the wraparound. This is an optional choice by the retiree or the employer. If they are the primary provider of the drug benefit, they would be covered by this amendment.

For employers intending to act as a supplement to the coverage, we decided that today; unfortunately, it was voted down. With that in mind, clearly in this bill most of us believe what we ought to be trying to do is support, not supplant, the valuable efforts of employers already providing prescription coverage to retirees.

As presently written, I am concerned the bill would lead many retiree benefit plans to scale back or drop entirely the prescription drug coverage they presently provide. However, this amendment would provide an increased subsidy to employers, because we want to encourage them to provide this benefit to retirees. It seems to me it is in our interest to encourage them to stay involved. They would get a subsidy, as long as they continue to offer prescription drug coverage to retirees only as the primary provider, not as a supplement—not as a wrap around the new Medicare benefit.

The scope of this problem is not small at all. In fact, I was surprised to learn how many seniors would be impacted by the unintended change to retiree benefit coverage. About one-third of all Medicare beneficiaries receive prescription drug coverage through an employer-sponsored health care plan. That is by far the largest source of prescription drug coverage for seniors.

These plans have played a very critical role in providing security to seniors, while Congress has been unable over the last number of years to pass a prescription drug benefit plan under Medicare. Retiree benefit plans should continue, in my view, to play that role even after a drug benefit plan is enacted. In many cases, the drug coverage provided by retiree benefit plans is significantly more generous than the plan we are debating here.

Furthermore, many seniors have become familiar and comfortable with the coverage offered by their former employers.

Understandably, they do not want to give it up for a plan about which they are confused and uncertain or may not be as beneficial to them.

We should be doing, in my view, everything in our power to provide these seniors with a choice, with the option of staying with their employer-sponsored plan. Thus, this amendment.

Unfortunately, the option may not be available for many seniors. That is why I put up this chart. I wish to focus the attention of those who may be following this debate to the left side of this chart. The right side I will talk about briefly, but the most significant numbers are on the left side of the chart. I will get to them in a minute.

While the numbers vary slightly, depending upon which study one consults, they come to the same conclusions, roughly the same numbers, and they are very disheartening. Between 1993 and 2001, the percentage of large employers, those who employ more than 500 people, offering coverage to Medicare-eligible retirees dropped from 40 to 23 percent, almost in half over 7 or 8 years. In the last 2 years, 13 percent of all employers offering future retiree coverage have elected not to do so. Those retaining coverage are experiencing annual cost increases on the order of 14 percent. It has been tremendously expensive. As a result, they are substantially raising the cost-sharing burdens for individuals enrolled in these plans.

The chart on the left-hand side illustrates the crisis that employer-sponsored plans are facing today and are going to continue to face in the future. The numbers are based on a survey conducted by the Kaiser Family Foundation and Hewitt Associates in December of 2002.

The graph shows that the actions large employers have taken over the last 2 years to deal with the rapidly increasing retiree health care cost—these numbers may not be clear to everyone, so I will recite them—a large number of employers have increased individual costs in some way. Forty-four percent have increased retiree contributions to premiums, while 36 percent increased cost sharing. In addition, 14 percent have shifted all costs to the individual retiree, and 13 percent have eliminated the plans altogether. Finally, nearly half of employers surveyed increased cost sharing for prescription drugs, as shown by the bar depicting 49 percent.

The numbers on this chart do not bode well, is the point I am trying to make, for those seniors who currently receive health care benefits from their former employers. Given the enormous financial pressures being felt by employers and the encouragement this bill already provides—in the form of a 64 percent subsidy—to keep employers from dropping coverage, it seems to me that if the employees decide to stay with their existing coverage, we believe that subsidy ought to go from 64 percent to 100 percent of the national average premium. That is what we are trying to do with this amendment.

The Congressional Budget Office has estimated that almost 40 percent of seniors who currently have their prescription drug medicines covered by retiree benefit plans would lose their coverage under the plan before us. So even with the 64 percent subsidy, 37 percent of retirees would be dropped from these plans. We are raising through this amendment that subsidy to 100 percent which we think will do a lot to keep these employer-based plans in place so that retirees would have that option of sticking with those retiree plans.

I supported the Rockefeller amendment. I mentioned that earlier. This is different. This is very different. If you are just supplementing the benefit plan, then you would not be covered by the Dodd amendment. That was the Rockefeller amendment, and the Senate voted it down. My amendment says only if you are the primary provider of the prescription drug benefit would you get the kind of subsidy we are talking about, from 64 to 100 percent. That would mean approximately an additional $400 a year per retiree paid to the employer. This would encourage employers to retain the full prescription drug coverage they presently provide rather than cutting back coverage and simply supplementing a new Medicare benefit.

The underlying bill has a provision that would provide a subsidy to employers for every Medicare-eligible retiree who elects to remain in an employer-sponsored plan as an alternative

to the Medicare prescription drug plan. That subsidy would be approximately, as I mentioned, 64 percent of the national average premium for prescription drug coverage.

This amendment would very simply increase that subsidy to the full national average premium. This would mean an additional $35 a month per beneficiary or roughly $400 a year paid directly to employer-sponsored plans as long as they continue to offer an alternative to Medicare prescription drug coverage, bringing the total subsidies to almost $100 per month when we combine the 64 percent that is in the bill and what we are adding with this amendment.

To receive this subsidy, employers would have to offer a prescription drug plan that is competitive with the Medicare benefit because the subsidy would only be paid for beneficiaries who remain in the employer-sponsored plan and do not enroll in Medicare Part C or D.

We simply cannot allow retiree benefit plans to disappear. That would be a great mistake, in my view. This amendment is designed to keep them if we can. It is a modest amendment considering the benefits that could accrue to the retirees, giving them the option of sticking with an employer-based plan.

If CBO is right, under the plan before us, almost 40 percent of these retirees will lose that prescription drug coverage under their employer-based plans. I do not think we want to have that happen. I urge the adoption of this amendment, and I hope my colleagues will be supportive of it.

I see the chairman of the committee who I know wants to respond to my amendment.

The PRESIDING OFFICER (Mr. ALEXANDER). The Senator from Iowa.

Mr. GRASSLEY. Mr. President, I wish to propound a unanimous consent request.

I ask unanimous consent that Senator DODD have up to 20 minutes and Senator GRASSLEY up to 10 minutes for debate on amendment Nos. 970 and 998 concurrently. I further ask unanimous consent that following that debate, the Senate proceed to a vote in relation to the amendment No. 970, to be followed by a vote in relation to amendment No. 998, with no second-degree amendments in order to the amendments prior to the vote. Finally, I ask unanimous consent that at 10 a.m. tomorrow the Senate proceed to a vote in relation to the Grassley, or his designee, amendment, regarding the benchmark, with no amendments in order to the amendment prior to the vote; provided further, that this vote be subject to the approval of both leaders.

The PRESIDING OFFICER. Is there objection?

Mr. REID. Reserving the right to object.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Mr. President, it is my understanding the Senator from Connecticut has graciously indicated the time he has used would be counted toward this time.

Mr. DODD. That is correct.

Mr. REID. That being the case, the vote will occur around 6:15 p.m., for the information of Members.

The PRESIDING OFFICER. Approximately 6:20 p.m. Is there objection? Without objection, it is so ordered.

Mr. DODD. Mr. President, if I can finish, I can give the chairman a chance to respond.

I ask unanimous consent that a letter signed by 33 of the labor unions in this country in support of my amendment be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

JUNE 23, 2003.

DEAR SENATOR: If the Medicare drug bill before the Senate, S. 1, becomes law, 37 percent of retirees who now have employer-sponsored health benefits will lose that coverage. That's 4.4 million retirees that will be made worse off if S. 1, as drafted, is enacted into law. Such an act will represent an enormous and irreversible blow to the employer-based system that is the backbone of our nation's health care system.

As you know, retiree health coverage is already in crisis. Drug costs constitute 40 to 60 percent of employers' retiree health care costs, and steep price increases are prompting employers to eliminate drug benefits, cap their contributions or drop retiree coverage altogether. In fact, just 34 percent of all large firms (200 or more employees) offered retiree benefits in 2002, down from 68 percent of all large firms in 1988.

Both public and private employers need immediate relief for their retiree prescription drug costs, but S. 1, as now drafted, will exacerbate an already dire situation for retiree coverage by discriminating against retirees with employer-sponsored coverage.

By using a trick definition of out of pocket costs—''true out of pocket''—S. 1 will effectively deny retirees catastrophic coverage by not counting any drug costs covered through an employer plan. This ensures seniors with retiree benefits will get less Medicare coverage than any other beneficiary. As a result, employers that choose to ''wrap around'' the Medicare benefit and provide assistance for costs not covered by Medicare will find the gap in coverage does not end for these retirees.

Two amendments will be offered to address this critical flaw. The first, offered by Senator Rockefeller, would eliminate the ''true out of pocket'' definition so that retirees receive the same benefit as all other beneficiaries. The second amendment, to be offered by Senator Dodd, would increase the subsidy to employers that retain retiree benefits.

Although some may claim that the ''true out of pocket'' trick will save money for Medicare, any provision that encourages employers to drop their retiree benefits will only end up costing the federal government more—and hurt millions of seniors in the process. Seniors who have retiree benefits have worked a lifetime and made wage concessions over the years with the expectation that they would have retiree benefits. To change the rules of the game at this point and give them less than other Medicare beneficiaries is patently unfair.

We urge you to support the amendments aimed at encouraging both public and private employers to continue providing retiree health benefits. Congress must enact a drug benefit that supports, not threatens our fragile employer-based system of health coverage.

We have many other concerns with the Senate bill, including the enormous gap in coverage and the reliance on uncertain and historically unstable private insurance plans. And we have very grave concerns that the conference report you will be asked to consider will incorporate elements of the House bill that are entirely unacceptable to the millions of American we represent. In particular, the House bill would introduce full competition into Medicare beginning in 2010—a blatant attempt to undermine the traditional Medicare program and start it on a ''death spiral'' of caring for the sickest beneficiaries and unsustainable costs.

We strongly believe that adding a prescription drug benefit to Medicare is the most urgently needed reform and one that has been promised to our nation's elderly and disabled. However, we cannot accept legislation that does so at the expense of retirees who now have employer-sponsored coverage and the very future of Medicare.

Thank you for your consideration.

Sincerely,

John J. Sweeney, President, AFL–CIO; Ron Gettelfinger, President, United Auto Workers; John J. Flynn, President, International Union of Bricklayers and Allied Craftworkers; Morton Bahr, President, Communications Workers of America; Harold A Schaitberger, President, International Association of Fire Fighters; Douglas H. Dority, International President, United Food and Commercial Workers.

James A. Grogan, Jr., President, Asbestos Workers, International Association of Heart and Frost Insulators; Frank Hurt, President, Bakery, Confectionary, Tobacco Workers and Grain Millers International Union; Edward C. Sullivan, President, Building and Construction Trades; Edwin D. Hill, President, International Brotherhood of Electrical Workers; Patricia Friend, International President, Association of Flight Attendants; Bobby L. Harnage Sr., President, American Federation of Government Employees.

David Holway, President, National Association of Government Union Employees/International Brotherhood of Police Officers; S. Richard Elliott, President, International Union of Journeymen, Horseshoers, United Services and Allied Trades; Terence M. O'Sullivan, President, Laborers' International Union; R. Thomas Buffenbarger, President, International Association of Machinists and Aerospace Workers; Thomas F. Lee, President, American Federation of Musicians of the United States and Canada.

Gregory Junemann, President, International Federation of Professional and Technical Engineers; Andrew L. Stern, President, Service Employees International Union; Gerald W. McEntee, President, American Federation of State, County and Municipal Employees; Sandra Feldman, President, American Federation of Teachers; Sonny Hall, President, Transport Workers Union of America; Donald Wightman, President, Utility Workers Union of America; George Tedeschi, President, Graphic Communications International Union; Joseph J. Hunt, General President, Iron Workers, International Association of Bridge, Structural, Ornamental and Reinforcing.

John M. Bowers, President, International Longshoremen's Association; Cecil E.

Roberts, President, United Mine Workers of America; Boyd D. Young, President, PACE International Union; Joe L. Greene, President, American Federation of School Administrators; Michael J. Sullivan, General President, Sheet Metal Workers International Union; Leo W. Gerard, President, United Steelworkers of America; James P. Hoffa, General President, International Brotherhood of Teamsters; Robert A. Scardelletti, President, Transportation Communications International Union.

Mr. DODD. Mr. President, I will read a pertinent passage because this is really the heart of this issue. I mentioned earlier, one-third of all retirees get coverage under the private employer-based plans. If CBO is right, almost 40 percent of retirees will lose their coverage under this bill, and employers would start dropping them because they do not get the subsidies, then I think we have to understand what the implications mean for a lot of people. I do not believe my colleagues intend this to be the case, but this is what is going to happen if we are not careful.

The letter reads in part:

If the Medicare drug bill before the Senate, S. 1, becomes law, 37 percent of retirees who now have employer-sponsored health benefits will lose that coverage.

That is according to CBO.

That's 4.4 million retirees that will be made worse off if S. 1, as drafted, is enacted into law. Such an act will represent an enormous and irreversible blow to the employer-based system that is the backbone of our nation's health care system.

The letter goes on:

. . . any provision that encourages employers to drop their retiree benefits will only end up costing the federal government more—and hurt millions of seniors in the process. . . .

We urge you to support the [Dodd] amendment aimed at encouraging both public and private employers to continue providing retiree health benefits. Congress must enact a drug benefit that supports, not threatens, our fragile employer-based system of health coverage.

That is what my amendment is designed to do: to provide that subsidy if the retiree takes the option of continuing in the employer-based plan as the primary provider for health care coverage. If that is the case, then I think we ought to provide that encouragement and inducement. They make a huge difference in people's lives. If CBO is right and we do not adopt this amendment, and 4.5 million people have a worse plan as a result of our action, we have taken a step back rather than a step forward for that many seniors in our country. I don't know of anyone in this Chamber who would like to be a party to that.

For those reasons, I hope my colleagues could support the man from Connecticut on his amendment.

Mr. GRASSLEY. I am glad to speak about the man from Connecticut and his amendment but not to support it.

First of all, we need to remember, with or without this subject before the Senate, these plans could be dropped without any hesitation. We can have the prescription drug plan before the Senate, and there could be some reason some companies would drop that. But right now, remember, our passage of this legislation is very much to fill a gap. We are worried about people who do not have any coverage whatever.

As I have said before, we are all very concerned about the future of retirees' benefits and making sure retirees are treated fairly. Under the beneficial before the Senate, retirees get the same protection from high prescription drugs and the costs as any other beneficiary. That is a generous subsidy, far greater than they currently get, which would be zero.

The fact is, typical retiree plans provide much more generous coverage, and the beneficiaries spend much less out of pocket for their prescriptions.

There has been a great deal of interest in the assumption by the Congressional Budget Office that corporations are going to drop their coverage of prescription drugs for about 37 percent of the retirees in retiree health plans over the next 10 years. What we cannot forget is employers, as I indicated, are already dropping or, maybe more, scaling back retiree health benefits not because of our legislation but because retiree health benefits are rising because of very high health care costs. They have already been dropping plans or cutting them back for at least a decade, a point made by my colleague, Senator DODD.

We have worked hard to address this problem in the underlying legislation. One of the most significant future liabilities faced by retiree plans is the cost of prescription drugs. We have given employers serious and generous subsidies. The Dodd amendment proposes to boost subsidies for employers beyond the 64 percent we have given them already. This change would send millions more in taxpayers dollars to these corporations during the next decade. We had to put priorities first.

We have $400 billion. We have looked at States and the problems of dual eligibles. We looked at corporate retiree plans and what might happen and what can we do to keep those that are going out of business or dumping theirs on a government plan. We have worked with a lot of different problems. We have had to do the best we can to squeeze within that $400 billion. We have tried to help the States to some extent on dual eligibles. We are trying to help corporations with incentives not to dump their retirees on this plan. I can go down a long list we have tried to squeeze in and prioritize.

The overriding goal was to help those who had no drug plans whatever. That was very much a high priority. We have maybe 30 percent or a little more on private plans. We have people on Medicare with Medigap policies. We have people who are duly eligible subject to Medicaid. But we have 30 percent or more with zilch. We go beyond just helping those who do not have any plan. But that has been our priority. We tried to do it in a way that people who have better—and maybe most corporate retiree plans do have better incentives than what we can provide—and they can continue to have better. But we cannot control entirely what corporations are going to do. Particularly, you cannot do that on the amount of money we have here.

As I indicated, this is a very expensive amendment that we cannot squeeze into the $400 billion.

I urge my colleagues to defeat the amendment. I yield the floor.

The PRESIDING OFFICER. The Senator from Connecticut.

Mr. DODD. I will take 1 minute on this amendment and move to my second amendment.

This is an optional choice. We are not requiring employers to retain an employer-based plan. We are saying we know already, based on CBO's analysis, that close to 40 percent of people under the employer-based plans will be dropped. We know that.

Our primary responsibility in this bill is to provide a good prescription drug benefit for people. We do not want to be in a situation of actually causing people to have a worse plan than they have.

My point is not to increase spending but to say, if you are going to provide prescription drug coverage as an employer—and I want you to continue doing this; and we are being told 37 percent of the people will be dropped—we will increase the subsidy. To encourage employers to continue doing it seems to me to be in our interest. That is why I offer this amendment and why it is so strongly supported by labor unions who believe this will be a major blow to almost 4.5 million retirees in the country. I urge adoption of this amendment.

AMENDMENT NO. 970

The second amendment I call up is amendment No. 970, and I ask for its immediate consideration.

The PRESIDING OFFICER. That amendment is pending.

Mr. DODD. Let me briefly explain this amendment. I commend the committee.

This bill does an awful lot for people who are really hurting. I want the chairman to know I strongly support his efforts. Those who are really hurting get real help with this bill. I commend the committee for focusing on that. I commend him for it.

What this amendment does is a little different. We have all been talking about donut holes. People watching this debate may wonder what we are talking about, but the donut hole is in the plan when you reach a certain level of your costs of prescription drugs. Even though you keep paying the premiums of $35 a month, if your costs run somewhere around $4,500 to $5,800, during that period you are in the eye of the hurricane, and you do not get any help during that period.

That is not true if you are below 160 percent of poverty. If you are below 160 percent of poverty, we will provide help to you even while you are in the donut hole.

My amendment effects those in the donut hole who are between 160 and 250 percent of poverty. That is an individual who makes $22,000 a year or a couple earning $30,000 a year. These are people who are really hurting out there as well. They are not as desperately poor as those at 160 percent of poverty, but they are not much better off. But just in the donut hole, could we say that those people might get a 50/50 deal in the donut hole, between 160 and 250 percent of poverty? In that one set of circumstances where the costs are running from $4,500 to $5,800, you get a 50/50 deal if you are making $22,500, or a couple, $30,000, that is what the amendment does.

I know the chairman is going to say these are great ideas and there is a cost associated, and there is. But we ought to provide some help to people in those earnings groups—$22,000 if you are single or $30,000 as a couple. These are probably cancer patients or patients with serious medical costs. If you are paying somewhere around $4,500 a year, up to $5,800 a year, you have a serious health care problem. If you are making $22,000 or $30,000, as an individual or a married couple, then to provide 50 percent of the cost of those prescription drugs while you are in that donut hole I do not think is asking too much of us.

We should add just a little bit to accommodate these not even middle-income people. It would be an unfair description to say these are middle-income people. There is nothing magic about 250 percent. I just tried to reach out a bit to that constituency here that will continue paying the $35 a month. They have to do that. They do not get anything. If we could just reach a little further to that constituency, beyond the 160 percent, between $4,500 and $5,800 in total spending. We try to provide an additional bit of help for you, 50 percent of that cost. We can't pick up all of it, that would probably be too expensive. I don't know what the CBO numbers would be, but we will put you in the 50/50 bracket up to 250 percent of poverty just while you are in that situation. That is what the amendment does. It is no more complicated than that.

Again, I compliment the chairman. They have done a very good job taking care of the very desperately poor in the country. But for people who are not quite desperately poor—although I suggest some may tell you that living on $22,000 a year as a single person or a couple over the age of 65 with $30,000 worth of income, they are not out partying. These people probably make choices between food and rent and medicines, particularly if you are paying $4,500 a year or up to $5,800 a year for prescription drugs. That comes off the $22,000 or your $30,000. You do not have to do the math to know where you are living, what circumstances you are under.

So this is designed to provide some additional relief for people in that category, moving it up just a little bit, up to that 250 percent from 160 percent while you are in the donut hole, only there, to get a 50/50 break. You still pay 50 percent of the cost. You don't get 100 percent relief, but 50 percent of the cost, and that is what the second amendment is designed to do.

I apologize for racing, but I am trying to get this in in the 5 minutes. This is obviously complicated stuff. I am trying to accommodate my colleagues who I know have other engagements this evening to explain what the amendments do. The time does not justify the context, as to how important this would be to a lot of people in this country. I don't know the numbers of the people in this income category, but I have to believe before we get done with this, to provide some additional help for people in that category ought not to be too much of a stretch when you consider that $22,450 for an individual and $30,000 for a couple is going to put a lot of burden, a lot of pressure on you if you are already paying somewhere between $4,500 and $5,800 in prescription drug costs. This amendment would help those people.

I hope the man from Connecticut might impress the chairman on this one with his support. Hope springs eternal. I keep knocking on the door, seeing if I can't get some help.

Mr. KENNEDY. I commend Senator DODD for offering this important amendment today. This amendment will address one of the gaping holes in this plan—its failure to treat retirees and retiree health plans fairly. Today, we have the opportunity—and the obligation—to correct that unfairness.

Ten million senior citizens depend on retiree health plans to fill the gaps in Medicare. Especially given the limitations of the drug benefit we are debating, supplemental coverage from retiree health plans is crucial. But retiree health plans are being abandoned or cut back all over the country—and prescription drug costs are a key part of the problem. For retirees who are over 65, prescription drugs make up about half of all plan costs—and as much as 80 percent of recent cost increases.

But the prescription drug plan before us treats those plans unfairly, by taking the unprecedented step of making senior citizens with retiree health plans second class citizens under Medicare. The Congressional Budget Office has concluded that even with the new assistance provided under this plan, one-third of all retirees—4 million senior citizens—could lose their supplemental drug coverage. That should be unacceptable to every Senator.

The issue is not one of providing a bail-out or a windfall to retiree health plans. It is one of simple fairness. Currently, whenever Medicare covers a benefit or service, Medicare is the primary payer for that service. If a retiree health plan covers the service, it pays only for what Medicare does not cover.

The reason for that is straightforward. Employers pay taxes to support the Medicare Program. So do retirees. So do active workers who accept lower wages during their working years in order to have supplemental retirement health care in their retirement years.

But under this legislation, these workers and these employers do not get the full benefit of their contribution to the drug benefit. Because of the ''true out-of-pocket'' concept included in the bill, Medicare does not pay for catastrophic expenses of these workers, even though the cost of covering these expenses accounts for more than one-third the cost of the current bill.

And the higher the costs the retiree faces, the more the discrepancy between what Medicare pays for the retiree with employer-sponsored insurance and what Medicare pays for all other senior citizens grows. If the individual's drug costs are $6,000, Medicare pays $2,113 for the retiree with insurance but $2,281 for all other senior citizens. If the individual's drug costs are $8,000, Medicare still pays $2,113 for the retiree with employer-sponsored insurance, but $4,081 for all other senior citizens. And if the individual's drug costs are $10,000, Medicare still pays just $2,113 for the retiree, but pays $5,881 for all other senior citizens.

This is double taxation at its worst. These retired workers and companies are taxed twice. They pay once to support the Mecicare program. Then they are forced to pay again by being denied the Medicare benefits their contributions have earned. During the debate on the tax bill we heard a lot about the injustice of double taxation of dividends from the other side of the aisle. Apparently, for them, double taxation of the unearned income of millionaires and billionaires is wrong, but double taxation of moderate income retired senior citizens is just fine.

The fact is that it is not fine. The American people understand that it is wrong. American companies struggling to provide for their retired workers in this sour economy understand that is wrong. The Senate should understand that it is wrong, too, and right this injustice.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Mr. President, how much time do I have?

The PRESIDING OFFICER. The Senator has 4 minutes.

Mr. DODD. I had 5.

Mr. GRASSLEY. First, let me explain to the distinguished Presiding Officer why we refer to ''the man from Connecticut.'' When I was going to yield him some time, I didn't think of the word ''Senator.'' I said I will give 1 minute to the man from Connecticut, and I apologize.

First of all, I wish I had an exact number for this amendment. It has

some costs, but I do not have an official score from the Congressional Budget Office so I cannot say that this costs X number of billions of dollars at this point. But it does have some cost.

I am going to try to convince the Senator from Connecticut that we have done a lot in this legislation for people who are low income. Maybe it doesn't go as high up the economic ladder as he would like to have us go. But my point is we have done an awful lot.

We worked very hard to minimize the gap in coverage with resources provided in the budget resolution which would be roughly $400 billion. The bill also provides generous coverage to lower income beneficiaries, those who have income below about $15,000, and couples with incomes below about $20,000. They, in fact, have no gap in coverage. That is 44 percent of Medicare beneficiaries who are completely unaffected by the benefit limit.

In the writing of this bill, a conscious decision was made to devote excess dollars to filling in the gap in coverage for all seniors. Under the underlying bill, the average senior at this income level will still save more than $1,600 annually off the drug spending after paying an affordable monthly premium of $35 per month. This is a savings of about 53 percent off annual drug costs for the average senior who would enroll in the drug benefit.

Let me remind everybody, this drug benefit is optional. People do not have to join it. If anybody is saying I don't want to pay $35 per month to get this sort of coverage, then that person does not have to pay $35 per month for coverage because this is a voluntary program. So the people who enroll in this program would save that $1,600, even beyond the $35-per-month premium.

While I appreciate what the Senator from Connecticut is trying to do, it cannot possibly fit within the $400 billion that we have. We had to draw a limit someplace. We drew the limit at 160 percent of poverty. So I cannot support his amendment. I am sorry to say that to the Senator from Connecticut.

The PRESIDING OFFICER. The Senator from Connecticut.

Mr. DODD. I thank the chairman. He has been very gracious. This is my last amendment. I have tried vainly over here in the last couple of days with some amendments—I don't know what the implications are; I appreciate his candor, in terms of not knowing the cost of this amendment—that would fill in the hole, to go from 160 to 250, for people in that category. The reason I offered it is it occurred to me if you are paying that much in prescription drugs, somewhere around $5,000 a year for prescription drugs, and you are making $30,000 as a couple or $22,000 as an individual, you probably have a pretty serious illness if you are paying about $5,000 in prescription drug costs.

It occurs to me that during that hole, we might try to do a little more. We have done that, as the chairman says, very graciously for the desperately poor in this country.

For those reasons, I urge the adoption of the amendment. I will let the chairman proceed. The first amendment, I guess, we will do in that order.

Mr. GRASSLEY. I yield any time I have and I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to amendment No. 970.

Mr. DODD. There are two amendments. Amendment No. 998?

The PRESIDING OFFICER. We will vote on one at a time. Amendment No. 970 is first.

Mr. GRASSLEY. Mr. President, while I am at it, I would like to ask for the yeas and nays on both the Dodd amendments.

The PRESIDING OFFICER. Is there objection to that request?

Without objection, it is so ordered. The yeas and nays are in order.

Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. The question is on agreeing to the amendment. The yeas and nays have been ordered.

The clerk will call the roll on amendment No. 970.

The assistant legislative clerk called the roll.

Mr. MCCONNELL. I announce that the Senator from Colorado (Mr. CAMPBELL) and the Senator from South Carolina (Mr. GRAHAM) are necessarily absent.

Mr. REID. I announce that the Senator from Florida (Mr. GRAHAM), the Senator from Massachusetts (Mr. KERRY), and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Florida (Mr. GRAHAM) and the Senator from Massachusetts (Mr. KERRY) would each vote ''yea.''

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 41, nays 54, as follows:

[Rollcall Vote No. 240 Leg.]

YEAS—41

Akaka	Dorgan	Lincoln
Bayh	Durbin	Mikulski
Biden	Edwards	Murray
Bingaman	Feingold	Nelson (FL)
Boxer	Feinstein	Nelson (NE)
Byrd	Harkin	Pryor
Cantwell	Hollings	Reed
Carper	Inouye	Reid
Clinton	Johnson	Rockefeller
Conrad	Kennedy	Sarbanes
Corzine	Kohl	Schumer
Daschle	Lautenberg	Stabenow
Dayton	Leahy	Wyden
Dodd	Levin	

NAYS—54

Alexander	DeWine	McCain
Allard	Dole	McConnell
Allen	Domenici	Miller
Baucus	Ensign	Murkowski
Bennett	Enzi	Nickles
Bond	Fitzgerald	Roberts
Breaux	Frist	Santorum
Brownback	Grassley	Sessions
Bunning	Gregg	Shelby
Burns	Hagel	Smith
Chafee	Hatch	Snowe
Chambliss	Hutchison	Specter
Cochran	Inhofe	Stevens
Coleman	Jeffords	Sununu
Collins	Kyl	Talent
Cornyn	Landrieu	Thomas
Craig	Lott	Voinovich
Crapo	Lugar	Warner

NOT VOTING—5

Campbell	Graham (SC)	Lieberman
Graham (FL)	Kerry	

The amendment (No. 970) was rejected.

Mr. GRASSLEY. I move to reconsider the vote.

Mr. NICKLES. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

VOTE ON AMENDMENT NO. 998

The PRESIDING OFFICER. The question is on agreeing to amendment No. 998. The yeas and nays have been ordered. The clerk will call the roll.

The legislative clerk called the roll.

Mr. MCDONNELL. I announce that the Senator from Colorado (Mr. CAMPBELL) is necessarily absent.

Mr. REID. I announce that the Senator from Florida (Mr. GRAHAM), the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote ''yea''.

The PRESIDING OFFICER (Mr. TALENT). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 41, nays 55, as follows:

[Rollcall Vote No. 241 Leg.]

YEAS—41

Akaka	Dorgan	Lincoln
Bayh	Durbin	Mikulski
Biden	Edwards	Murray
Bingaman	Feingold	Nelson (FL)
Boxer	Feinstein	Nelson (NE)
Byrd	Harkin	Pryor
Cantwell	Hollings	Reed
Carper	Inouye	Reid
Clinton	Johnson	Rockefeller
Conrad	Kennedy	Sarbanes
Corzine	Kohl	Schumer
Daschle	Lautenberg	Stabenow
Dayton	Leahy	Wyden
Dodd	Levin	

NAYS—55

Alexander	Burns	DeWine
Allard	Chafee	Dole
Allen	Chambliss	Domenici
Baucus	Cochran	Ensign
Bennett	Coleman	Enzi
Bond	Collins	Fitzgerald
Breaux	Cornyn	Frist
Brownback	Craig	Graham (SC)
Bunning	Crapo	Grassley

Gregg	McCain	Snowe
Hagel	McConnell	Specter
Hatch	Miller	Stevens
Hutchison	Murkowski	Sununu
Inhofe	Nickles	Talent
Jeffords	Roberts	Thomas
Kyl	Santorum	Voinovich
Landrieu	Sessions	Warner
Lott	Shelby	
Lugar	Smith	

NOT VOTING—4

Campbell	Kerry
Graham (FL)	Lieberman

The amendment (No. 998) was rejected.

Mr. REID. Mr. President, I move to reconsider the vote and I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. REID. I ask unanimous consent that the Democratic leader be recognized to speak next, and following his statement the Senator from Georgia be recognized to speak, both as if in morning business. The Senator from Georgia will speak for up to 7½ minutes; I don't know how long Senator DASCHLE is going to speak, but I don't think it will be long.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. While we are waiting for Senator DASCHLE, if we could reverse the order and have the Senator from Georgia proceed.

The PRESIDING OFFICER. The Senator from Georgia.

(The remarks of Mr. MILLER are printed in Today's RECORD under ''Morning Business.'')

(The remarks of Mr. DASCHLE are printed in Today's RECORD under ''Morning Business.'')

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. I ask unanimous consent the pending amendment be set aside and Senator CONRAD be recognized to offer a series of amendments, and following his offering amendments the Senator from New York, Senator CLINTON, be recognized to offer her amendments.

I state for the information of Senators, the manager or I will also have some other amendments to offer on behalf of other Senators. Following that, there should be no more business of the Senate.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from North Dakota.

AMENDMENTS NOS. 1019, 1020, 1021

Mr. CONRAD. Mr. President, I say to my colleague who is seeking to also introduce amendments, I will be very brief.

I rise to offer three amendments to the Prescription Drug and Medicare Improvement Act. I send the three to the desk.

The PRESIDING OFFICER. The clerk will report the amendments by number.

The legislative clerk read as follows:

The Senator from North Dakota [Mr. CONRAD], for himself, Mrs. MURRAY, Mr. SMITH, Mrs. LINCOLN, and Mr. JEFFORDS, proposes an amendment numbered 1019.

The Senator from North Dakota [Mr. CONRAD] proposes an amendment numbered 1020.

The Senator from North Dakota [Mr. CONRAD] proposes an amendment numbered 1021.

Mr. CONRAD. I ask unanimous consent the reading of the amendments be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendments are as follows:

AMENDMENT NO. 1019

(Purpose: To provide for coverage of self-injected biologicals under part B of the medicare program until Medicare Prescription Drug plans are available)

At the end of subtitle B of title IV, insert the following:

SEC. ___. MEDICARE COVERAGE OF SELF-INJECTED BIOLOGICALS.

(a) COVERAGE.—

(1) IN GENERAL.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended—

(A) in subparagraph (U), by striking ''and'' at the end;

(B) in subparagraph (V), by inserting ''and'' at the end; and

(C) by adding at the end the following new subparagraph:

''(W)(i) a self-injected biological (which is approved by the Food and Drug Administration) that is prescribed as a complete replacement for a drug or biological (including the same biological for which payment is made under this title when it is furnished incident to a physicians' service) that would otherwise be described in subparagraph (A) or (B) and that is furnished during 2004 or 2005; and

''(ii) a self-injected drug that is used to treat multiple sclerosis;''.

(2) CONFORMING AMENDMENT.—Subparagraphs (A) and (B) of section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) are each amended by inserting '', except for any drug or biological described in subparagraph (W),'' after ''which''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to drugs and biologicals furnished on or after January 1, 2004 and before January 1, 2006.

At the end of title VI, add the following:

SEC. ___. MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking ''promptly (as determined in accordance with regulations)''; and

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

''(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98–369).

(b) CLARIFYING AMENDMENTS TO CONDITIONAL PAYMENT PROVISIONS.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: ''An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.'';

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: ''A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.''; and

(B) in the final sentence, by striking ''on the date such notice or other information is received'' and inserting ''on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received''; and

(3) in subparagraph (B)(iii), as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: ''In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.''.

(c) CLERICAL AMENDMENTS.—Section 1862(b)(42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking ''such'' before ''paragraphs''.

AMENDMENT NO. 1020

(Purpose: To permanently and fully equalize the standardized payment rate beginning in fiscal year 2004)

Strike section 401 and insert the following:

SEC. 401. EQUALIZING URBAN AND RURAL STANDARDIZED PAYMENT AMOUNTS UNDER THE MEDICARE INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM.

(a) IN GENERAL.—Section 1886(d)(3)(A)(iv)(42 U.S.C. 1395ww(d)(3)(A)(iv)) is amended—

(1) by striking ''(iv) For discharges'' and inserting ''(iv)(I) Subject to subclause (II), for discharges''; and

(2) by adding at the end the following new subclause:

''(II) For discharges occurring in a fiscal year beginning with fiscal year 2004, the Secretary shall compute a standardized amount for hospitals located in any area within the United States and within each region equal to the standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for hospitals located in any area) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.''.

(b) CONFORMING AMENDMENTS.—

(1) COMPUTING DRG-SPECIFIC RATES.—Section 1886(d)(3)(D) (42 U.S.C. 1395ww(d)(3)(D)) is amended—

(A) in the heading, by striking ''IN DIFFERENT AREAS'';

(B) in the matter preceding clause (i), by striking '', each of'';

(C) in clause (i)—

(i) in the matter preceding subclause (I), by inserting ''for fiscal years before fiscal year 2004,'' before ''for hospitals''; and

(ii) in subclause (II), by striking ''and'' after the semicolon at the end;

(D) in clause (ii)—

(i) in the matter preceding subclause (I), by inserting ''for fiscal years before fiscal year 2004,'' before ''for hospitals''; and

(ii) in subclause (II), by striking the period at the end and inserting ''; and''; and

(E) by adding at the end the following new clause:

''(iii) for a fiscal year beginning after fiscal year 2003, for hospitals located in all areas, to the product of—

''(I) the applicable standardized amount (computed under subparagraph (A)), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C) for the fiscal year; and

''(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.''.

(2) TECHNICAL CONFORMING SUNSET.—Section 1886(d)(3) (42 U.S.C. 1395ww(d)(3)) is amended—

(A) in the matter preceding subparagraph (A), by inserting '', for fiscal years before fiscal year 1997,'' before ''a regional adjusted DRG prospective payment rate''; and

(B) in subparagraph (D), in the matter preceding clause (i), by inserting '', for fiscal years before fiscal year 1997,'' before ''a regional DRG prospective payment rate for each region,''.

At the end of title VI, add the following:

SEC. ___. MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking ''promptly (as determined in accordance with regulations)''; and

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

''(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98–369).

(b) CLARIFYING AMENDMENTS TO CONDITIONAL PAYMENT PROVISIONS.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: ''An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.'';

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: ''A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.''; and

(B) in the final sentence, by striking ''on the date such notice or other information is received'' and inserting ''on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received''; and

(3) in subparagraph (B)(iii), as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: ''In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.''.

(c) CLERICAL AMENDMENTS.—Section 1862(b)(42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking ''such'' before ''paragraphs''.

AMENDMENT NO. 1021

(Purpose: To address medicare payment inequities)

At the end of subtitle A of title IV, add the following:

SEC. ___. GEOGRAPHIC RECLASSIFICATION OF CERTAIN HOSPITALS FOR PURPOSES OF REIMBURSEMENT UNDER THE MEDICARE PROGRAM.

(a) IN GENERAL.—Notwithstanding any other provision of law, effective for discharges occurring during fiscal year 2004 and each subsequent fiscal year, for purposes of making payments under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), hospitals located in the Bismarck, North Dakota Metropolitan Statistical Area are deemed to be located in the Fargo-Moorhead North Dakota-Minnesota Metropolitan Statistical Area.

(b) TREATMENT AS DECISION OF MEDICARE GEOGRAPHIC CLASSIFICATION REVIEW BOARD.—

(1) IN GENERAL.—Except as provided in paragraph (2), for purposes of section 1886(d) of the Social Security Act (42 U.S.C 1395ww(d)), any reclassification under subsection (a) shall be treated as a decision of the Medicare Geographic Classification Review Board under paragraph (10) of that section.

(2) NONAPPLICATION OF 3-YEAR APPLICATION PROVISION.—Section 1886(d)(10)(D)(v) of the Social Security Act (42 U.S.C. 1395ww(d)(10)(D)(v)), as it relates to a reclassification being effective for 3 fiscal years, shall not apply with respect to reclassifications made under this section.

(c) PROCESS FOR APPLICATIONS TO ENSURE THAT PROVISIONS APPLY BEGINNING OCTOBER 1, 2003.—The Secretary shall establish a process for the Medicare Geographic Classification Review Board to accept, and make determinations with respect to, applications that are filed by applicable hospitals within 90 days of the date of enactment of this section to reclassify based on the provisions of this section in order to ensure that such provisions shall apply to payments under such section 1886(d) for discharges occurring on or after October 1, 2003.

(d) ADJUSTMENTS TO ENSURE BUDGET NEUTRALITY.—If 1 or more applicable hospital's applications are approved pursuant to the process under subsection (c), the Secretary shall make a proportional adjustment in the standardized amounts determined under paragraph (3) of such section 1886(d) for payments for discharges occurring in fiscal year 2004 to ensure that approval of such applications does not result in aggregate payments under such section 1886(d) that are greater or less than those that would otherwise be made if this section had not been enacted.

AMENDMENT NO. 1019

Mr. CONRAD. Mr. President, the first amendment would provide immediate prescription assistance to certain chronically ill beneficiaries. We have a very curious circumstance. Under current law, Medicare Part B covers injectable drugs if they are routinely administered by a physician in the office. However, if a similar drug is available that could be self-injected at home, it is not covered.

That makes no sense at all. This policy causes a significant burden for seniors with certain illnesses such as multiple sclerosis, rheumatoid arthritis, and other diseases. This amendment would address this problem by providing immediate coverage of drugs that could be administered at home when they are used to replace drugs that are covered when given in a physician's office. This transitional benefit would expire when a comprehensive Medicare drug benefit is implemented in 2006.

I am proud to say I am working on this effort with Senator MURRAY of Washington, who has introduced similar legislation in bill form; Senator SMITH, who is also on the Finance Committee, who has been a leading advocate of this approach; Senator LINCOLN; and Senator JEFFORDS. It is supported by more than 40 patient organizations.

This is a common-sense policy which provides real and immediate help to thousands of America's seniors. It is entirely paid for by codifying that Medicare is the secondary payer when beneficiaries have other private insurers that provide them with coverage.

I hope my colleagues will look with favor on this amendment.

AMENDMENT NO. 1020

The second amendment would address payment inequity that has hurt America's rural hospitals. As many know, rural health care providers are often forced to operate with significantly less resources than larger urban facilities. In my State of North Dakota, rural hospitals often receive only one-half the reimbursement their urban counterparts get for treating the exact same illness.

For example, a rural facility in North Dakota receives approximately $4,200 for treating pneumonia, while a hospital in New York receives more than $8,500 to treat that same illness. The funding disparity is simply unfair and has placed many rural providers on shaky ground.

To address this situation, MedPAC has recommended various policies, including equalizing the standard payment amount, which has been 1.6 percent higher for urban facilities. There is no policy basis for this difference.

Earlier this year the omnibus appropriations bill took steps to equalize the standardized amount but only until the end of fiscal year 2003. This amendment finishes the job by making this change permanent.

Again, this amendment is fully paid for by the legislation codifying that Medicare is the secondary payer when beneficiaries have alternative coverage.

AMENDMENT NO. 1021

Finally, I am offering a third amendment that would address a disparity related to whether certain hospitals are eligible to be reclassified for the purposes of the in-patient hospital wage index.

Under current law, hospitals have to meet certain mileage or proximity requirements in order to reclassify to the wage index value applied to another area of the State. In rural States such as North Dakota, this restriction has produced unfair, certainly unintended, consequences.

In my State, there are hospitals on the western side of North Dakota which are hundreds of miles from the eastern side of the State but compete for the same labor pool—compete for the same doctors, the same nurses—and have the same costs. However, because of this mileage restriction, they are not able to get paid the same. In fact, there is an 18-percent difference in the wage index between hospitals in Bismarck, ND, and hospitals in Fargo, ND—an 18-percent difference. It makes no earthly sense.

North Dakota hospitals have tried to address this situation by appealing to CMS on various occasions, to no avail. And the reason it has been to no avail is because the law says you have to be contiguous. Well, there is a 200-mile difference between Bismarck and Fargo, but they are in contiguous markets. They compete for the same doctors, the same nurses, and they need to be treated in the same way.

This amendment would address this situation by allowing certain hospitals in my State to reclassify to another area of the State for purposes of the wage index. This change would be budget neutral.

I urge my colleagues to support these three important amendments.

Let me just say, if I can, to my colleagues, I am also working on a fourth amendment, the dialysis annual update formula. I am working on that with Senator SANTORUM and the chairman and ranking member. We are hopeful of being able to work out that amendment at a later point.

Mr. President, these are the amendments I am seeking to have considered.

AMENDMENT NO. 1019

Mr. SMITH. Mr. President, I rise today with my colleague from North Dakota in support of critical drug coverage for beneficiaries who contend with the debilitating effects of Multiple Sclerosis. This amendment would provide transitional coverage for the four FDA-approved therapies in the 2-year interim until 2006, when the prescription drug plan will take effect.

Approximately 400,000 Americans have MS. In my home State of Oregon, it is estimated that there are 5,800 people living with MS. Currently, Medicare covers only one of the four FDA-approved MS therapies and only when administered by a physician.

This amendment would cover all four MS therapies, including when they are administered by the patients themselves, providing better coverage and better care for Americans with Multiple Sclerosis. While these therapies do not cure MS, they can slow its course, and have provided great benefit to MS patients.

It is critical that MS patients have access to all approved drugs because some MS patients do not respond well to, or cannot tolerate, the one MS therapy that is currently covered. Currently, many Medicare beneficiaries with MS are forced to take the less effective therapy, to pay the costs out of pocket, or forgo treatment.

Equally, this amendment is important to rural Medicare beneficiaries with MS. By administering drugs themselves, rural beneficiaries can avoid the costs and hassles of traveling long distances to health care facilities to receive their MS therapy.

In the spirit of providing all Medicare beneficiaries with increased choice, MS patients need and deserve the full range of treatment choices currently available and self-administration helps ensure access to needed medications. I urge my colleagues on both sides of the aisle to join me in support of this amendment and to provide adequate and comprehensive drug coverage for MS patients.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Mr. President, with the graciousness of the Senator from New York, I ask unanimous consent that the Senator from Washington be recognized for up to 3 minutes to speak on one of the amendments offered by the Senator from North Dakota.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mrs. MURRAY. Mr. President, I thank my colleague from New York.

AMENDMENT NO. 1019

Mr. President, I have a statement I will give for the RECORD, but I also want to thank Senator CONRAD for his work on the self-injected biologics and the offering of this amendment tonight. I am delighted to be a cosponsor on this amendment. It is something I have worked on for over 2 years. And as Senator CONRAD said, we have patients today with MS, with rheumatoid arthritis, who are forced to go to a doctor, a medical clinic in order to get the drugs they need.

This will save us money in the long run because people will be able to stay home. But, most importantly, it will allow people quality of life in the care they need. I thank Senator CONRAD and Senator SMITH and the other cosponsors of this amendment.

Mr. President, I am pleased to join with Senator CONRAD and Senator SMITH in offering this amendment to give those on Medicare access to a new, exciting group of drugs known as self-injected biologics.

Senator CONRAD offered a similar amendment during the Senate Finance Committee markup and received a commitment from the chair to work with us on this effort.

As a result of this commitment, Senator CONRAD withdrew the amendment. We have been working with CBO and Senator BAUCUS' staff to address any concerns.

Currently, Medicare will only cover biologics if they are administered in a physician's office or clinical setting. That means patients must travel to the physician's office to receive treatment. This is not easy for many patients who have rheumatoid arthritis or MS—two diseases that can severely limit a person's mobility.

Fortunately, there are versions of these drugs that a patient can take in their own home. It is a great innovation that will improve a patient's access.

Unfortunately, Medicare won't cover biologics that are administered in the home. That just doesn't make sense. I have been working to correct this inequity for the past 2 Congresses.

The Murray-Conrad-Smith amendment would provide 2 years of coverage, under Part B, for those self-injected biologics that replace treatments currently available only in a physician's office.

We allow for 2-year coverage to bridge the gap to implementation of a Medicare prescription drug benefit.

We have received a CBO score for the 2 years and believe that we can find room in 2004 and 2005 to provide this important coverage for MS and RA patients.

This legislation is strongly endorsed by the Arthritis Foundation and will provide additional coverage to all four MS self-injected or self-administered treatments.

For MS, only one treatment is covered under Medicare, provided in a physician's office.

I am hopeful that the managers of this legislation will be able to accept our amendment and end this discriminatory practice in Medicare.

Mr. President, I thank the Senator from New York.

The PRESIDING OFFICER. The Senator from North Dakota.

Mr. CONRAD. Mr. President, I appreciate very much the leadership Senator MURRAY has provided on this issue. I really took her legislation and, because I am a member of the Finance Committee, I had an opportunity to offer it. But I want to make clear, this is a bill Senator MURRAY introduced. I was proud to pick it up in the Finance Committee so it could be offered at the appropriate time there.

I thank her for her leadership. I think we are close to getting this accomplished. It will be a great tribute to the Senator from Washington and the legislative leadership she has provided.

The PRESIDING OFFICER. The Senator from New York.

Mrs. CLINTON. Mr. President, I join with my colleague from North Dakota in thanking the Senator from Washington for championing this cause for so long because it is clearly long overdue. And I thank both Senators for presenting it to us in this context. I look forward to supporting it.

Mr. President, I ask unanimous consent that the pending amendments be temporarily set aside so I may offer several amendments.

The PRESIDING OFFICER. That authority has already been granted.

AMENDMENTS NOS. 1000 AND 999

Mrs. CLINTON. Mr. President, I rise today to speak of four amendments I have filed. And I would like to discuss each in turn, starting with amendment No. 1000, offered on behalf of myself, Senator TIM JOHNSON, and Senator——

The PRESIDING OFFICER. If the Senator will suspend for a moment, we are trying to find the amendments here at the desk.

The clerk will report the amendments that are at the desk.

The assistant legislative clerk read as follows:

The Senator from New York [Mrs. CLINTON], for herself, Mr. JOHNSON, and Mr. BINGAMAN, proposes an amendment numbered 1000.

The Senator from New York [Mrs. CLINTON] proposes an amendment numbered 999.

The amendments are as follows:

AMENDMENT NO. 1000

(Purpose: To study the comparative effectiveness and safety of important Medicare covered drugs to ensure that consumers can make meaningful comparisons about the quality and efficacy)

At the end of title VI, add the following:

SEC. ___. STUDY ON EFFECTIVENESS OF CERTAIN PRESCRIPTION DRUGS.

(a) IN GENERAL.—

(1) RESEARCH BY NIH.—The Director of the National Institutes of Health, in coordination with the Director of the Agency for Healthcare Research and Quality and the Commissioner of Food and Drugs, shall conduct research, which may include clinical research, to develop valid scientific evidence regarding the comparative effectiveness and, where appropriate, comparative safety of covered prescription drugs relative to other drugs and treatments for the same disease or condition.

(2) ANALYSIS BY AHRQ.—

(A) IN GENERAL.—The Director of the Agency for Healthcare Research and Quality, taking into consideration the research and data from the National Institutes of Health and the Food and Drug Administration, shall use evidence-based practice centers to synthesize available data or conduct other analyses of the comparative effectiveness and, where appropriate, comparative safety of covered prescription drugs relative to other drugs and treatments for the same disease or condition.

(B) SAFETY.—In any analysis of comparative effectiveness under this subparagraph, the Director of the Agency for Healthcare Research and Quality shall include a discussion of available information on relative safety.

(3) STANDARDS.—The Director of the Agency for Healthcare Research and Quality, in consultation with the Commissioner of Food and Drugs, the Director of the National Institutes of Health, and with input from stakeholders, shall develop standards for the design and conduct of studies under this subsection.

(b) COVERED PRESCRIPTION DRUGS.—For purposes of this section, the term ''covered prescription drugs'' means prescription drugs that, as determined by the Director of the Agency for Healthcare Research and Quality in consultation with the Administrator of the Centers for Medicare & Medicaid Services, account for high levels of expenditures, high levels of use, or high levels of risk to individuals in federally funded health programs, including Medicare and Medicaid.

(c) DISSEMINATION.—

(1) ANNUAL REPORT.—Each year the Secretary shall prepare a report on the results of the research, studies, and analyses conducted by the National Institutes of Health and the Agency for Healthcare Research and Quality, and the Food and Drug Administration under this section and submit the report to the following:

(A) Congress.

(B) The Secretary of Defense.

(C) The Secretary of Veterans Affairs.

(D) The Administrator of the Centers for Medicare & Medicaid Services.

(E) The Director of the Indian Health Service.

(F) The Director of the National Institutes of Health.

(G) The Director of the Office of Personnel Management.

(H) The Commissioner of Food and Drugs.

(2) REPORTS FOR PRACTITIONERS.—As soon as possible, but not later than a year after the completion of any study pursuant to subsection (a)(2), the Director of the Agency for Healthcare Research and Quality shall—

(A) prepare a report on the results of such study for the purpose of informing health care practitioners; and

(B) transmit the report to the Director of the National Institutes of Health.

(3) FDA DRUG INFORMATION.—The Commissioner of Food and Drugs shall—

(A) review all data and information from studies and analyses conducted or prepared under this section; and

(B) develop appropriate summaries of such information for inclusion in adequate directions for use under section 502(f)(1) of the Federal Food, Drug, and Cosmetic Act and in summaries relating to side effects, contraindications, and effectiveness under section 502(n) of that Act.

(4) NIH INTERNET SITE.—The Director of the National Institutes of Health shall publish on the Institutes' Internet site and through other means that will facilitate access by practitioners, each report prepared under this subsection by the Director of the Agency for Healthcare Research and Quality.

(d) EVIDENCE.—In carrying out this section, the Director of the National Institutes of Health and the Agency for Healthcare Research and Quality shall consider only methodologically sound studies, giving preference to studies for which the Directors have access to sufficient underlying data and analysis to address any significant concerns about methodology or the reliability of data.

(e) AUTHORIZATIONS OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $75,000,000 for fiscal year 2004, and such sums as may be necessary for each fiscal year thereafter.

AMENDMENT NO. 999

(Purpose: To provide for the development of quality indicators for the priority areas of the Institute of Medicine, for the standardization of quality indicators for Federal agencies, and for the establishment of a demonstration program for the reporting of health care quality data at the community level)

On page 389, between lines 6 and 7, insert the following:

SEC. ___. PRIORITY AREA QUALITY INDICATORS.

(a) IN GENERAL.—The Director of the Agency for Healthcare Research and Quality, in consultation with the Quality Interagency Coordination Task Force, the Institute of Medicine, the Joint Commission on Accreditation of Healthcare Organizations, the National Committee for Quality Assurance, the American Health Quality Association, the National Quality Forum, and other individuals and organizations determined appropriate by the Secretary of Health and Human Services, shall assemble, evaluate, and, where necessary, develop or update quality indicators for each of the 20 priority areas for improvement in health care quality as identified by the Institute of Medicine in their report entitled ''Priority Areas for National Action'' in 2003, in order to assist medicare beneficiaries in making informed choices about health plans. The selection of appropriate quality indicators under this subsection shall include the evaluation criteria formulated by clinical professionals, consumers, data collection experts.

(b) RISK ADJUSTMENT.—In developing the quality indicators under subsection (a), the Director of the Agency for Healthcare Research and Quality shall ensure that adequate risk adjustment is provided for.

(c) BEST PRACTICES.—In carrying out this section, the Director of the Agency for Healthcare Research and Quality shall—

(1) assess data concerning appropriate clinical treatments based on the best scientific evidence available;

(2) determine areas in which there is insufficient evidence to determine best practices; and

(3) compare existing quality indicators to best clinical practices, validate appropriate indicators, and report on areas where additional research is needed before indicators can be developed.

(d) REPORT.—Not later than 1 year after the date of enactment of this Act, and annually thereafter, the Director of the Agency for Healthcare Research and Quality shall—

(1) submit to the Director of the National Institutes of Health a report concerning areas of clinical care requiring farther research necessary to establish effective clinical treatments that will serve as a basis for quality indicators; and

(2) submit to Congress a report on the state of quality measurement for priority areas that links data to the report submitted under paragraph (1) for the year involved.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $12,000,000 for fiscal year 2004, and $8,000,000 for each of fiscal years 2005 through 2009.

SEC. ___. STANDARDIZED QUALITY INDICATORS FOR FEDERAL AGENCIES.

(a) IN GENERAL.—In addition to other activities to be carried out by the Quality Interagency Coordination Taskforce (as established by executive order on March 13, 1998), such Taskforce shall standardize indicators of health care quality that are used in all Federal agencies, as appropriate.

(b) CONSULTATION.—In carrying out subsection (a), the Quality Interagency Coordination Taskforce shall consult with a public-private consensus organization (such as the National Quality Forum) to enhance the likelihood of the simultaneous application of the standardized indicators under subsection (a) in the private sector.

(c) REPORT.—Not later than 1 year after the date of enactment of this Act, and annually thereafter, the Secretary of Health and Human Services shall submit to Congress a report on the progress made by the Quality Interagency Coordination Taskforce to standardizing quality indicators throughout the Federal Government.

SEC. ___. DEMONSTRATION PROGRAM FOR COMMUNITY HEALTH CARE QUALITY DATA REPORTING.

(a) IN GENERAL.—The Secretary of Health and Human Services, acting through the Director of the Centers for Disease Control and Prevention and the Director of the Agency for Healthcare Quality and Research, shall award not to exceed 20 grants to eligible communities for the establishment of demonstration programs for the reporting of health care quality information at the community level.

(b) QUALITY INDICATORS.—

(1) IN GENERAL.—For purposes of reporting information under the demonstration programs under this section, indicators of health care quality may include the indicators developed for the 20 priority areas as identified by the Institute of Medicine in the report entitled ''Priority Areas for National Action'', 2003, or other indicators determined appropriate by the Secretary of Health and Human Services.

(2) TYPE OF DATA.—All quality indicators with respect to which reporting will be carried out under the demonstration program shall be reported by race, ethnicity, gender, and age.

(c) ELIGIBILITY.—The Secretary of Health and Human Services shall award grants to communities under this section based on competitive proposals and criteria to be determined jointly by the Director of the Centers for Disease Control and Prevention and the Director of the Agency for Healthcare Research and Quality. Such criteria may include a demonstrated ability of the community to collect data on quality indicators and a demonstrated ability to effectively transmit community-level health status results to relevant stakeholders.

(d) TECHNICAL ADVISORY COMMITTEE.—The Secretary of Health and Human Services shall establish a technical advisory committee to assist grantees in data collection, data analysis, and report dissemination.

(e) REPORT.—Not later than 1 year after the date of enactment of this Act, and annually thereafter, the Director of the Centers for Disease Control and Prevention and the Director of the Agency for Healthcare Research and Quality shall—

(1) submit to the Congress a report on the results of the demonstration programs under this section; and

(2) make such reports publicly available, including by posting the reports on the Internet.

(f) EVALUATION.—The Secretary of Health and Human Services shall, upon awarding grants under subsection (a), enter into a contract for the evaluation of demonstration programs under this section. Such evaluation shall compare the effectiveness of such demonstration programs in collecting and reporting required data, and on the effectiveness of distributing information to key stakeholders in a timely fashion. Such evaluations shall provide for a report on best practices.

(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $25,000,000 for fiscal year 2004, and such sums as may be necessary for each fiscal year thereafter.

The PRESIDING OFFICER. The Senator from New York.

Mrs. CLINTON. Thank you, Mr. President.

AMENDMENT NO. 1000

Mr. President, amendment 1000, offered on behalf of myself and Senators TIM JOHNSON and JEFF BINGAMAN, is being offered to ensure our seniors have information they need to make informed consumer choices about their drugs, and also to ensure practitioners have the information needed to choose the right drug for a patient, and, further, that the private plans this bill would create have the information they need to make formulary and benefit design choices based on sound science.

This amendment ensures that various Government agencies—NIH, FDA, CMS, and the others involved in this effort—conduct research comparing the efficacy and, if applicable, the comparative safety of the top drugs used by Medicare and Medicaid beneficiaries who are Medicare eligible.

Now often there are a number of competing drugs to treat the same condition. But which is more effective? Oftentimes we just do not know.

While the FDA is responsible for determining safety and effectiveness of prescription drugs compared to a placebo, there is no Government entity responsible for examining whether drug A is more effective at treating a particular condition than drug B. Meanwhile, drug companies do not always have an incentive to do head-to-head trials of the drugs they put out versus those of their competitors. But this information is critical to all decisionmakers, to patients and consumers, to practitioners, and to the private plans that are being created.

Now clinicians have told me they are frequently trying to decide whether to switch a patient from an old drug to a new drug. They are not deciding between the old drug and a placebo; they are deciding between a drug they have used for a particular patient and then one which has come to their attention because it is now on the market, and they are trying to decide: Which is best for my patient? They wish they had more information that would enable them, besides trial and error and possible adverse consequences, to make that determination.

Clearly, consumers will also benefit from more sources of information. Right now advertising is a source available to consumers, but this amendment will help us provide an unbiased, scientific source of information that consumers can compare side by side rather than just a beautiful advertisement of people running through a field or twirling their grandchildren and then being told: This is the drug for the condition you have. They will be able to say: Well, wait a minute. Here is the drug I have been prescribed, here is a drug I have heard about. Let me look on the Internet to see what the differences might be.

Now we have all heard of ''me too'' drugs, and there is nothing wrong with ''me too'' drugs. Sometimes a ''me too'' drug will work incrementally better than a previous drug or it may be better tolerated. Even if a ''me too'' drug does not have those characteristics, it might be superior for a certain portion of the population but not for others. The problem is, we do not have that kind of comparative data.

My amendment directs NIH to do comparative efficacy trials for the top Medicare drugs—the ones that are primarily prescribed for the Medicare population—for the kinds of conditions the Medicare population primarily suffers from.

No single study will settle that question once and for all, so my amendment then directs the Agency for Health Research and Quality, AHRQ, to do what it does best, which is to synthesize the literature that is out there as well as the NIH data to report information on the comparative efficacy of these medical interventions that we are subsidizing now in this bill for our seniors.

HHS will then make this comparative information available to clinicians, to Congress, to relevant Federal agencies. And it will, most particularly and importantly, make that available to seniors so they can make informed choices for themselves.

Under this amendment, we would put this information on the Internet. FDA would look at whether this information needs to be included in drug labels, and drug ads would also contain this information so that they do not mislead seniors.

One indicator of the rarity of these studies is that completion of a comparative efficacy study can make national news. For example, many of us

read last December when the National Heart, Lung, and Blood Institute published a study and discovered that it corrected the assumption that newer drugs, such as calcium channel blockers and ACE inhibitors, which cost 30 to 40 times more than diuretics, were not more effective than those long-time treatments for high blood pressure. This is information we have needed for years. We have one of the most advanced health care systems, if not the most advanced, in the world. If the information stream our doctors count is such a tiny trickle that the daily news can keep track of all major developments, then this amendment must be passed in order to give us a sound scientific basis for the decisions that are going to be made with the $400 billion that we are allocating.

When the research is done, as we learned about in the calcium channel blockers and ACE inhibitors versus old-fashioned diuretics, it is important and its benefits are immediately obvious.

In January 2003, the American Journal of Ophthalmology published an article comparing the efficacy of two glaucoma drugs. One is latanoprost and the other bimatoprost. These were compared in an NIH-sponsored randomized clinical trial. Despite the fact that the Latanoprost is currently the most popular medication, the study found that Bimatoprost was more effective.

This is critically important because if we are going to be putting money into drugs and we are going to be holding out the promise to our seniors that finally help is on the way, then let's make sure these tax dollars are used to fund the drugs that are most effective.

In 1999, an NIH-sponsored study showed that a well-known, safe, cheap generic drug, Metoprolol, was just as effective for treating patients with heart failure as a more expensive drug which had come on to the market just a few years earlier. Some may say these studies could promote a one-size-fits-all approach to prescribing, but to the contrary, these studies can actually help make prescribing more nuanced and appropriate to each subpopulation.

For instance, in March 2003, the American Journal of Cardiology reviewed numerous clinical trials of medications used to treat what is called atrial fibrillation, a type of heart arrhythmia, and came up with recommendations about what are the most effective drugs for use for this condition based on what the underlying cause of the condition was in each case.

As someone who is fast approaching the age of Medicare eligibility, I want, both for my pocketbook and my health, to know that my doctor and I have the best information available about which drug is appropriate for me. And I certainly think that we can, through this amendment, begin to provide that information to ensure that seniors and their physicians have good, solid data on which to make their decisions.

This amendment is supported by a number of groups that are aware of the significance of trying to put into this bill some scientifically based data on which to make these decisions. The RxHealth Value Coalition is supporting the amendment. I have a letter from them. They consist of not only large employers—Verizon, General Motors, Ford, et cetera—but Blue Cross, Blue Shield, Kaiser, AARP, and many others.

I ask unanimous consent to print the RxHealth Value letter of June 24, 2003, supporting this amendment, in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

RXHEALTHVALUE,
Washington, DC, June 24, 2003.

Hon. HILLARY RODHAM CLINTON,
U.S. Senate,
Russell Senate Office Building,
Washington, DC.

DEAR SENATOR CLINTON: As the 108th Congress considers reforming the Medicare program and addressing one of the programs major shortcomings—lack of an outpatient prescription drug benefit, we want to express support for your amendment to the Medicare legislation being considered by the Senate that would provide limited support for the Centers of Medicare and Medicaid Services, the Center for Medicare Choices, which would be created by S. 1, the National Institutes of Health and the Agency for Healthcare Research and Quality to collaborate on studies to compare the relative efficacy and safety of prescription medicines designed to treat the same condition. It is this very information that is vital to patients, practitioners, and purchasers. With comparative information on prescription medicines patients, practitioners and purchasers can make better decisions with respect to choosing the prescription medicines to take, prescribe, cover, and pay for.

RxHealthValue is a national coalition of large employers, consumer groups, labor unions, health plans, health care providers and pharmacy benefit managers that, through its members, represents almost 100 million Americans. RxHealthValue is committed to research, education and both public- and private-sector solutions to ensure that Americans receive the full health and economic value from their prescription drugs. The Coalition's definition of ''value'' includes effectiveness, cost, appropriate use and safety.

Your amendment is a very important component of any Medicare prescription drug benefit proposal, since it is imperative that the federal Centers for Medicare & Medicaid Services (CMS) and the proposed Center for Medicare Choices (CMC) have the needed information to be a prudent purchaser of prescription drugs. We are pleased that you ask the National Institutes of Health (NIH) to add to the very limited research results from which evidence-based reviews get their information, and that you recognized the importance of dissemination so that information gets to providers and consumers when they need it. We agree that AHRQ's Evidence-based Practice Centers (EPCs), which have been involved in the innovative Oregon prescription drug program, would be an outstanding vehicle for such reviews.

This legislation is especially important as Congress works to provide Medicare beneficiaries with high quality outpatient drug coverage. We applaud your efforts on this important amendment and look forward to working with you and others to ensure that improved information on prescription drugs is available to all.

For more information on RxHealth's position on this and other drug value initiatives, please contact Steve Cole, RxHealthValue Policy Committee Chair, at 202–296–1314.

Again, thank you from the member organizations of RxHealthValue:

Blue Cross/Blue Shield.
Kaiser.
AARP.
National Consumers League.
Verizon.
Association of Community Health Plans.
General Motors.
Ford.
Daimler Chrysler.
Families USA.
National Organization of Rare Disorders.
American Academy of Family Physicians.
Academy of Managed Care Pharmacy.
UAW.
AFSCME.
Pacific Business Group on Health.
Midwest Business Group on Health.
Washington Business Group on Health.
Advance–PCS.
Caremark Rx.
AFL–CIO.

Mrs. CLINTON. Similarly, I have a letter from Consumers Union, dated June 24, 2003, which also supports amendment No. 1000, and I ask unanimous consent that letter, too, be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

CONSUMERS UNION,
June 24, 2003.

Hon. TIM JOHNSON,
U.S. Senate,
Washington, DC.

DEAR SENATOR JOHNSON: Consumers Union strongly supports your amendment that would provide for study by the National Institute of Health and the Agency for Healthcare Research and Quality of the comparative effectiveness of prescription drugs. The development of scientific evidence-based information about the relative effectiveness of drugs has the potential to dramatically increase consumers' (and taxpayers') bang-for-the-buck paid for prescription drugs.

Millions of Medicare beneficiaries (in addition to the tens of millions of uninsured and underinsured consumers nationwide) are paying increasing out-of-pocket costs for their prescription drugs. Despite these escalating costs, it is often difficult for consumers and health care professionals to ensure that consumers receive value for each healthcare dollar spent.

The proposed amendment would create a resource for independent information about the comparative medical effectiveness of important medicines. We believe that this information will substantially reduce the nation's prescription drug expenditures, because consumers and doctors will be able to make decisions using reliable evidence-based information about comparative effectiveness. The amendment would require this information to be made available through the Internet to the public. As a result, consumers, employers, state governments and the federal government will have access to information that will enable them to choose more cost-effective medicines without sacrificing medical effectiveness or quality of care.

Sincerely,

GAIL E. SHEARER,
Director, Health Policy Analysis,
Washington Office.

Mrs. CLINTON. Finally, I have a letter from Families USA, dated June 24, 2003, that similarly supports the amendment. I will read the following paragraph from it:

It would be unfortunate if Congress decides to spend $400 billion on pharmaceuticals over the next decade, without providing a few dollars to ensure that what we are buying is indeed worth buying.

I ask unanimous consent that letter be printed in the RECORD as well.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

FAMILIES USA,
June 24, 2003.

HON. HILLARY RODHAM CLINTON,
U.S. Senate,
Washington, DC.

DEAR SENATOR CLINTON: Congratulations on your amendment to help Americans understand which prescription drugs are truly effective and safe. Families USA, the national health consumer advocacy organization, strongly endorses the effort of you and Senator Johnson to provide reliable, unbiased information on pharmaceuticals.

Too often today, prescription drug information is influenced by the manufacturer, by advertisements, and by clinical studies financed by those who will gain from favorable reports. Americans need an objective, reliable source of information on which prescription drugs are most effective.

It would be unfortunate if Congress decides to spend $400 billion on pharmaceuticals over the next decade, without providing a few dollars to ensure that what we are buying is indeed worth buying.

Thank you again for you leadership on this important health consumer initiative.

Sincerely,

RONALD F. POLLACK,
Executive Director.

Mrs. CLINTON. Mr. President, if we are serious about making changes that will improve the health of our seniors on Medicare, I hope that we look to establish in this bill the proposition that good information, solid science that can be made available to seniors, to clinicians, to plans, be part of what we are establishing with the proposition that this money needs to be well spent, well spent not only to safeguard the taxpayers' dollars but well spent to ensure that our doctors and patients get the best possible treatment.

I also am offering amendment No. 999 that is intended to ensure that Medicare plans compete to improve rather than cut corners on quality. This bill already includes a measure that I have supported, along with Senator HATCH and others, to commission the Institute of Medicine to ensure the Medicare Program pays plans for providing higher quality care.

Unfortunately, even for the many common diagnoses and treatments that are part of a senior's medical history, we lack the quality standards that the Medicaid Program would use to help consumers make informed comparisons and choices among health plans.

For some diseases, the National Commission for Quality Assurance does collect information about health plans by providing data, for example, on how well HMOs screen for breast cancer or provide flu shots for older adults.

For many other diseases, however, we do not know which plans make sure that their diabetic patients get their eyes examined for retinal damage, what percent of asthmatics receive adequate therapy to control their asthma, or many other issues that go to the heart of the quality of health care that is being provided to our seniors.

The data tells us that Medicare beneficiaries are often not receiving the care they need to maintain their health. In 2001, for example, 23 percent of Medicare beneficiaries in private health plans did not have their cholesterol managed after a heart attack.

Now, my amendment is based on recommendations made by the Institute of Medicine. It authorizes a collaborative effort among the relevant Government agencies to develop quality indicators in the 20 most important areas identified in this Institute of Medicine report entitled ''Priority Areas for National Action.'' It authorizes the Quality Interagency Coordination Task Force—that is a task force that brings together all the Federal agencies that are needed to collect health quality data—to implement these indicators so that they are all collecting quality information in the same way. The Secretary of Health and Human Services would then develop demonstration programs for communities to engage in community-wide reporting, according to these quality indicators.

This amendment also has the potential to lower the cost of the Medicare Program. Because plans will provide quality measures that consumers will use, health plans will want to implement those quality improvement measures that have also been proven to lower health care costs. One such program, as an example, is a diabetes intervention program implemented by Group Health Cooperative, a group model health plan in Washington State. This intervention program improved diabetic blood sugar control and saved between $685 and $950 annually from reduced hospital admissions, emergency department visits, and physician consultations.

This is the kind of emphasis on quality that I think we need to put into this bill. Otherwise, as we try to make sense of the variety of options and choices that are available, we are not going to know what improved quality or what decreases costs. That should be one of our goals, and this amendment holds out the promise that the Medicare Program, with proper implementation of quality indicators, can do both—improve health and quality control and decrease costs.

AMENDMENT NO. 953

Mrs. CLINTON. Mr. President, I will also be talking about amendment No. 953, which is at the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from New York [Mrs. CLINTON] proposes an amendment numbered 953.

Mrs. CLINTON. Mr. President, I ask unanimous consent that further reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To provide training to long-term care ombudsman)

On page 608, between lines 10 and 11, insert the following:

SEC. ___. TRAINING FOR LONG-TERM CARE OMBUDSMAN.

(a) IN GENERAL.—The Secretary of Health and Human Services, acting through the Director of the Administration on Aging and in consultation with the Director of the Agency for Healthcare Research and Quality and the Administrator of the Centers for Medicare & Medicaid Services, shall authorize a program, to be developed and implemented by the National Long-Term Care Ombudsman Resource Center, for the training of long-term care ombudsmen in the use of quality of care information.

(b) TRAINING.—Under the program developed under subsection (a), training shall be provided to long-term care ombudsman to enable such ombudsman to educate consumers concerning—

(1) nursing home quality of care issues;

(2) available nursing home quality of care reports, including existing quality data that the Administrator of the Centers for Medicare & Medicaid Services has released for use by the public in choosing long-term care facilities; and

(3) the manner in which an individual can successfully integrate quality information into health care decision making regarding nursing home decisions.

(c) DUTIES OF RESOURCE CENTER.—The National Long-Term Care Ombudsman Resource Center shall—

(1) develop and maintain a curriculum for ombudsmen;

(2) develop, produce, and maintain training materials;

(3) conduct train-the-trainer programs at regional and national levels; and

(4) act as a clearinghouse for best practices in communicating the significance of nursing home quality indicators to residents and their caregivers.

(d) PILOT PROGRAMS.—The Secretary of Health and Human Services shall award grants for the establishment of 1-year pilot demonstration programs in 10 States using long-term care ombudsmen to educate consumers regarding home health care quality. Such pilot demonstration programs shall test the effectiveness of having a committed position within the State dedicated to helping consumers use home health care quality indicators.

(e) REPORT.—Not later than 18 months after the date of enactment of this Act, and annually thereafter, the Secretary of Health and Human Services shall submit to Congress a report concerning the effectiveness of the program established under this section, including the benefits of providing for dedicated staff who are responsible for educating consumers to use home health quality indicators in their health care decision-making.

(f) AUTHORIZATION.—In addition to any other amounts authorized to be appropriate for long-term care ombudsman programs, there are authorized to be appropriated to carry out this section $4,000,000 for fiscal year 2004 (of which $1,000,000 shall be used to carry out subsection (d)), and $2,000,000 for each fiscal year thereafter.

Mrs. CLINTON. Mr. President, amendment No. 953 would empower Medicare beneficiaries and their families in making decisions about nursing

homes and home health services. Data on nursing home quality is publicly available through a project strongly supported by Administrator Scully, and I am very appreciative of that because that information is imperative.

However, I know from talking with people throughout New York that there are still many problems in nursing homes with respect to errors and mishaps that undermine the quality of care, the quality of life and, in some respects, even the health of the nursing home residents. Many people still don't know about this existing quality data and about the existing ombudsman program within the administration on aging that is intended to help families navigate nursing home decisions.

This amendment would establish a national long-term care ombudsman resource center, which will help to develop and train ombudsmen. The amendment would establish pilot programs, including grants to create ombudsman offices in 10 States. These are the people—it should really be ''ombudspeople,'' I guess—who are uniquely positioned to know about the facilities they serve. They visit the facilities regularly. They are often located at agencies in the local communities. They have firsthand knowledge. They are very valuable resources. However, their knowledge, if it doesn't actually get to the users, the nursing home residents and, more importantly, their family members or advocates, doesn't help anyone.

This pilot project would fund specific ombudsman programs to provide comprehensive outreach, public education, and individual consultation that integrate quality information into health care decisionmaking. Through this pilot project, the ombudsman center would be able to identify the resources needed to actually provide consumer education on long-term care and home health, as well as best practices and collaborative models that could then be replicated around the country.

I ask my colleagues also to support this amendment because, again, I think information is critical. We talk about trying to create more of a market for these health care resources. Markets exist on information. A market without good information is not really a market at all. So if we are going to move toward the private market and provide these private health plans as competition to the existing Medicare delivery system, then I think we have to do more than just talk about the market. We need to empower the consumers within the marketplace. Information is that basis for empowerment.

AMENDMENT NO. 954

Mrs. CLINTON. Mr. President, I ask the clerk to report amendment No. 954, which is at the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from New York [Mrs. CLINTON] proposes an amendment numbered 954.

Mrs. CLINTON. Mr. President, I ask unanimous consent that further reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To require the Secretary of Health and Human Services to develop literacy standards for informational materials, particularly drug information)

On page 46, between lines 13 and 14, insert the following:

''(i) HEALTH LITERACY STANDARDS.—

''(1) IN GENERAL.—For purposes of assisting eligible entities in providing quality assurance measures as described in subsection (c)(1)(B), the Secretary, acting through the Director of the Agency for Healthcare Research and Quality, the Administrator of Health Resources and Services Administration, the Director of the National Library of Medicine, and the Commissioner of Food and Drugs, shall develop standardized materials that pharmacists may use to assist non-English speaking or functionally illiterate patients in the safe and appropriate use of prescription drugs. Such materials may include the use of pictures and the development of standardized translations in multiple languages of prescription labels and bottle labels and other patient safety initiative information. Such materials shall be available electronically for direct access by pharmacists.

''(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, such sums as may be necessary for each of fiscal years 2004 and 2005.

Mrs. CLINTON. Mr. President, this amendment is intended to improve the safety of the prescription drug program. As our seniors are using a growing number of medications to stay out of the hospital, to live healthier and longer lives, we are inadvertently, but inevitably, creating a burden on our seniors to understand and know how to use all of these prescription drugs. There are interactions, there are other issues, there are many problems with trying to sort out for our seniors how drugs work, how they interact with one another. This is a very important issue that I think, again, we need to address at the beginning of this process, not after some additional problems have been discovered.

In a recent study of adverse drug events published in the Journal of the American Medical Association, 21 percent of preventable adverse drug events were caused by patients not following drug prescription instructions. That is just human nature. People make mistakes and, as you get older, it is harder to read all that little writing on the prescription bottles. That is something that just kind of comes with the process. Of course, we have many people for whom English is not their first language. We have others who have challenges with eyesight and literacy. So, clearly, our seniors, like the rest of us, could make mistakes.

Studies have found that one-third of patients often don't take the prescription the way they are supposed to because they don't understand it. Now, if you have a dose of a three-times-a-day antibiotic, and you also have other prescription drugs to be taken five, six, seven times a day, or whatever the combination is, there are all kinds of opportunities for confusion because many seniors take complex drugs with multiple dangerous side effects, often much more serious than those from antibiotics. They are more likely to suffer injuries and hospitalizations as a result. As many as 60 percent of the elderly have these problems about understanding and following the directions. This is a very critical statistic. Twenty-three percent of nursing home admissions in our country result from the inability of older Americans to manage their medication at home.

That is why I am offering this amendment to ensure that the Secretary of HHS works to ensure the use of health literacy standards and information that will minimize adverse drug events, to ensure that we develop drug informational materials for non-English-speaking people and the functionally illiterate patients that can be made available to pharmacists who can access them electronically for easy use.

So, Mr. President, these amendments can be summed up in a very few words: enhanced quality, lower cost.

If we enhance quality, we avoid a lot of the problems that exist in our system today. We learn more about quality. We empower patients, as well as clinicians, with information that can better determine quality outcomes, and we save money. We do not have people being admitted to the hospital because they mix up their drugs. We do not have people trying to figure out how they can get good information about quality standards in nursing homes. We have all kinds of issues that cost money, as well as put the health and well-being of our seniors at risk.

I ask that my colleagues favorably consider these amendments. There is no cost attached to these amendments, but they will do what we hope to achieve by this significant legislation: improve quality for our seniors and lower costs in the long run by making prescription drugs readily available and understanding appropriately their use.

Mr. President, I thank you for your kind attention, and I yield the floor.

AMENDMENT NO. 1000

Mr. JOHNSON. Mr. President, I join my colleagues Senators CLINTON and BINGAMAN today to offer an amendment to S. 1 that will provide consumers and practitioners with real, objective information regarding the comparative effectiveness of prescription drugs.

Too often, prescription drug information is influenced by drug manufacturers, through advertisements, and by clinical studies financed by those who will gain from favorable reports. Consumers are just inundated with information—from direct-to-consumer advertising on drugs which can paint a misleading picture, to a sea of free

drug samples from their physicians—with all this information it can be extremely difficult to make a sound decision which can be just overwhelming for average Americans.

But what does the data really say about differing prescription drug options? Does a newer drug that costs more than an earlier version necessarily do a better job for most patients? Is it possible that a Medicare beneficiary may get the same, or even better outcome from the drug that has been on the market for a longer time? We just really don't have the answers to these—questions at least from independent, objective sources.

We are about to create a massive new program that will effect 40 million Americans and with this comes responsibility to deliver a program that ensures the availability of appropriate prescription drugs for all beneficiaries. This amendment will create a reliable source for valid, evidence-based information about the comparative medical effectiveness of medicines used by Medicare beneficiaries. It will provide unbiased information on how drugs that treat particular diseases and conditions compare to one another.

By authorizing the National Institutes of Health, in coordination with the Agency for Healthcare Research and Quality to conduct research on comparative effectiveness of drugs, consumers, employers, State governments and the Federal Government will finally have access to information that will enable them to choose medicines based on clinical research. This information will be made available to help them make better decisions with respect to choosing the prescription medicines to take, prescribe, cover and pay for. By using the objective, scientific expertise available at NIH and AHRQ, this amendment assures that the information received comes from independent and impartial sources.

This amendment is supported by RxHealthValue, a national coalition of large employers, consumer groups, labor unions, health plans, health providers and pharmacy benefit managers that through its members represent almost one-hundred million Americans. It is also supported by Families USA and Consumers Union.

This amendment preserves individuals' freedom to get any medicine that they want, but would encourage the use of medicines that are scientifically proven more effective for patients. It will not create ''one-size-fits-all'' medicine as Republicans will try and tell you. It does nothing to prevent independent decisionmaking by practitioners and their patients, just better educated decisionmaking.

Our Republican colleagues believe in the strength of the free market. Well, a well functioning marketplace depends on the free flow of information. Denying consumers and providers, as well as other purchasers of prescription drugs access to comparative information about effectiveness means that decisions in the marketplace are made without perfect information—which should not be the case in an open market. You are not going to buy a car without taking a look at Consumer Reports are you? Are you only going to base your purchase on the glitzy adds in ''Car and Driver'' magazine? I think we all know the answer to this is ''no'', and most certainly Medicare beneficiaries should have access to similar information for drugs they put in their bodies as they do for the car they drive.

AMENDMENT NO. 985, AS MODIFIED

Mr. REID. Mr. President, on behalf of Senator EDWARDS of North Carolina, I send a modification to the desk, and I ask unanimous consent the amendment be so modified.

The PRESIDING OFFICER. Without objection, it is so ordered. The amendment will be so modified.

The amendment (No. 985), as modified, is as follows:

At the end, add the following:

TITLE ___—DIRECT-TO-CONSUMER PRESCRIPTION DRUG ADVERTISING

SEC. ___01. HEAD-TO-HEAD TESTING AND DIRECT-TO-CONSUMER ADVERTISING.

(a) NEW DRUG APPLICATION.—Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) is amended—

(1) in subparagraph (A) of the second sentence of subsection (b)(1), by inserting before the semicolon at the end the following ''(including, if the Secretary so requires, whether the drug is safe and effective for use in comparison with other drugs available for substantially the same indications for use prescribed, recommended, or suggested in the labeling proposed for the drug)''; and

(2) in subsection (d)(5)—

(A) by inserting ''(A)'' after ''will''; and

(B) by inserting after ''thereof'' the following: ''or (B), if the Secretary has required information related to comparative safety and effectiveness, offer a benefit with respect to safety or effectiveness (including effectiveness with respect to a subpopulation or condition) that is greater than the benefit offered by other drugs available for substantially the same indications for use prescribed, recommended, or suggested in the labeling proposed for the drug''.

(b) MISBRANDING.—Section 502(n)(3) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 352(n)(3)) is amended by inserting after ''effectiveness'' the following: ''(including effectiveness in comparison to other drugs for substantially the same condition or conditions if such comparative information is available)''.

(c) REGULATIONS.—

(1) IN GENERAL.—Not later than 180 days after the date of enactment of this Act, the Secretary of Health and Human Services shall promulgate amended regulations governing prescription drug advertisements.

(2) CONTENTS.—In addition to any other requirements, the regulations under paragraph (1) shall require that—

(A) any advertisement present a fair balance, comparable in depth and detail, between—

(i) information relating to effectiveness of the drug (including effectiveness in comparison to similar drugs for substantially the same condition or conditions if such comparative information is available);

(ii) information relating to side effects and contraindications; and

(B) any advertisement present a fair balance comparable in depth, between—

(i) aural and visual presentations relating to effectiveness of the drug; and

(ii) aural and visual representations relating to side effects and contraindications, provided that, nothing in this section shall require explicit images or sounds depicting side effects and contraindications;

(C) prohibit false or misleading advertising that would encourage a consumer to take the prescription drug for a use other than a use for which the prescription drug is approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355); and

(D) require that any prescription drug that is the subject of a direct-to-consumer advertisement include in the package in which the prescription drug is sold to consumers a medication guide explaining the benefits and risks of use of the prescription drug in terms designed to be understandable to the general public.

SEC. ___02. CIVIL PENALTY.

Section 303 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 333) is amended by adding at the end the following:

''(h) DIRECT-TO-CONSUMER PRESCRIPTION DRUG ADVERTISING.—

''(1) IN GENERAL.—A person that commits a violation of section 301 involving the misbranding of a prescription drug (within the meaning of section 502(n)) in a direct-to-consumer advertisement shall be assessed a civil penalty if—

''(A) the Secretary provides the person written notice of the violation; and

''(B) the person fails to correct or cease the advertisement so as to eliminate the violation not later than 180 days after the date of the notice.

''(2) AMOUNT.—The amount of a civil penalty under paragraph (1)—

''(A) shall not exceed $500,000 in the case of an individual and $5,000,000 in the case of any other person; and

''(B) shall not exceed $10,000,000 for all such violations adjudicated in a single proceeding.

''(3) PROCEDURE.—Paragraphs (3) through (5) of subsection (g) apply with respect to a civil penalty under paragraph (1) of this subsection to the same extent and in the same manner as those paragraphs apply with respect to a civil penalty under paragraph (1) or (2) of subsection (g).''.

SEC. ___03. REPORTS.

The Secretary of Health and Human Services shall annually submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report that, for the most recent 1-year period for which data are available—

(1) provides the total number of direct-to-consumer prescription drug advertisements made by television, radio, the Internet, written publication, or other media;

(2) identifies, for each such advertisement—

(A) the dates on which, the times at which, and the markets in which the advertisement was made; and

(B) the type of advertisement (reminder, help-seeking, or product-claim); and

(3)(A) identifies the advertisements that violated or appeared to violate section 502(n) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 352(n)); and

(B) describes the actions taken by the Secretary in response to the violations.

SEC. ___04. REVIEW OF DIRECT-TO-CONSUMER DRUG ADVERTISEMENTS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall expedite, to the maximum extent practicable, reviews of the legality of direct-to-consumer drug advertisements.

(b) POLICY.—The Secretary of Health and Human Services shall not adopt or follow

any policy that would have the purpose or effect of delaying reviews of the legality of direct-to-consumer drug advertisements except—

(1) as a result of notice-and-comment rulemaking; or

(2) as the Secretary determines to be necessary to protect public health and safety.

AMENDMENT NO. 1036

Mr. REID. Mr. President, I ask unanimous consent that the pending amendments be set aside, and I send an amendment to the desk on behalf of Senator BOXER. This is an amendment to eliminate the coverage gap for individuals with cancer.

The PRESIDING OFFICER. Without objection, the clerk will report.

The assistant legislative clerk read as follows:

The Senator from Nevada [Mr. REID], for Mrs. BOXER, proposes an amendment numbered 1036.

Mr. REID. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To eliminate the coverage gap for individuals with cancer)

On page 53, between line 8 and 9, insert the following:

''(6) NO COVERAGE GAP FOR ELIGIBLE BENEFICIARIES WITH CANCER.—

''(A) IN GENERAL.—In the case of an eligible beneficiary with cancer, the following rules shall apply:

''(i) Paragraph (2) shall be applied by substituting 'up to the annual out-of-pocket limit under paragraph (4)' for 'up to the initial coverage limit under paragraph (3)'.

''(ii) The Administrator shall not apply paragraph (3), subsection (d)(1)(C), or paragraph (1)(D), (2)(D), or (3)(A)(iv) of section 1860D–19(a).

''(B) PROCEDURES.—The Administrator shall establish procedures to carry out this paragraph. Such procedures shall provide for the adjustment of payments to eligible entities under section 1860D–16 that are necessary because of the rules under subparagraph (A).''

AMENDMENT NO. 1037

Mr. REID. Mr. President, I ask unanimous consent that the pending amendments be set aside, and I send an amendment to the desk on behalf of Mr. CORZINE. This is a technical amendment regarding federally qualified health centers.

The PRESIDING OFFICER. Without objection, the clerk will report.

The assistant legislative clerk read as follows:

The Senator from Nevada [Mr. REID], for Mr. CORZINE, proposes an amendment numbered 1037.

Mr. REID. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To permit medicare beneficiaries to use Federally qualified health centers to fill their prescriptions)

At the end of subtitle A of title I, add the following:

SEC. ___. CONFORMING CHANGES REGARDING FEDERALLY QUALIFIED HEALTH CENTERS.

(a) PERMITTING FQHCS TO FILL PRESCRIPTIONS.—Section 1861(aa)(3) (42 U.S.C. 1395x(aa)(3)) is amended—

(1) in subparagraph (A), by striking ''and'' after the comma at the end;

(2) in subparagraph (B), by inserting ''and'' after the comma at the end; and

(3) by adding at the end the following new subparagraph:

''(C) drugs and biologicals for which payment may otherwise be made under this title,''.

(b) ELIMINATION OF PER VISIT LIMIT.—Section 1833(a)(3) (42 U.S.C. 1395l(a)(3)) is amended by inserting '', except that such regulations may not limit the per visit payment amount with regard to drugs and biologicals described in section 1861(aa)(3)(C)'' after ''the Secretary may prescribe in regulations''.

AMENDMENT NO. 1038

Mr. REID. Mr. President, I ask unanimous consent that the pending amendments be set aside, and I send an amendment to the desk on behalf of Senator JEFFORDS dealing with critical access to hospitals.

The PRESIDING OFFICER. Without objection, the clerk will report.

The assistant legislative clerk read as follows:

The Senator from Nevada [Mr. REID], for Mr. JEFFORDS, proposes an amendment numbered 1038.

Mr. REID. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To improve the critical access hospital program)

At the end of section 405 add the following:

(g) EXCLUSION OF CERTAIN BEDS FROM BED COUNT AND REMOVAL OF BARRIERS TO ESTABLISHMENT OF DISTINCT PART UNITS.—

(1) EXCLUSION OF CERTAIN BEDS FROM BED COUNT.—Section 1820(c)(2) (42 U.S.C. 1395i-4(c)(2)) is amended by adding at the end the following:

''(E) EXCLUSION OF CERTAIN BEDS FROM BED COUNT.—In determining the number of beds of a facility for purposes of applying the bed limitations referred to in subparagraph (B)(iii) and subsection (f), the Secretary shall not take into account any bed of a distinct part psychiatric or rehabilitation unit (described in the matter following clause (v) of section 1886(d)(1)(B)) of the facility, except that the total number of beds that are not taken into account pursuant to this subparagraph with respect to a facility shall not exceed 25.''.

(2) REMOVING BARRIERS TO ESTABLISHMENT OF DISTINCT PART UNITS BY CRITICAL ACCESS HOSPITALS.—Section 1886(d)(1)(B) (42 U.S.C. 195ww(d)(1)(B)) is amended by striking ''a distinct part of the hospital (as defined by the Secretary)'' in the matter following cause (v) and inserting ''a distinct part (as defined by the Secretary) of the hospital or of a critical access hospital''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to determinations with respect to distinct part unit status, and with respect to designations, that are made on or after October 1, 2003.

AMENDMENT NO. 1039

Mr. REID. Mr. President, I ask unanimous consent that the pending amendments be set aside, and I send an amendment to the desk on behalf of Senator INOUYE dealing with Native Hawaiians.

The PRESIDING OFFICER. Without objection, the clerk will report.

The assistant legislative clerk read as follows:

The Senator from Nevada [Mr. REID], for Mr. INOUYE, proposes an amendment numbered 1039.

Mr. REID. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To amend title XIX of the Social Security Act to provide 100 percent reimbursement for medical assistance provided to a Native Hawaiian through a Federally-qualified health center or a Native Hawaiian health care system)

At the appropriate place, insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Native Hawaiian Medicaid Coverage Act of 2003''.

SEC. 2. 100 PERCENT FMAP FOR MEDICAL ASSISTANCE PROVIDED TO A NATIVE HAWAIIAN THROUGH A FEDERALLY-QUALIFIED HEALTH CENTER OR A NATIVE HAWAIIAN HEALTH CARE SYSTEM UNDER THE MEDICAID PROGRAM.

(a) MEDICAID.—Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended, in the third sentence, by inserting '', and with respect to medical assistance provided to a Native Hawaiian (as defined in section 12 of the Native Hawaiian Health Care Improvement Act) through a Federally-qualified health center or a Native Hawaiian health care system (as so defined) whether directly, by referral, or under contract or other arrangement between a Federally-qualified health center or a Native Hawaiian health care system and another health care provider'' before the period.

(b) EFFECTIVE DATE.—The amendment made by this section applies to medical assistance provided on or after the date of enactment of this Act.

Mr. REID. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. SESSIONS. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. SESSIONS. Mr. President, I ask unanimous consent that the pending amendments be set aside so that I may speak on my amendment No. 1011.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 1011

Mr. SESSIONS. Mr. President, the bill we are moving forward today is a prescription drug bill, a Medicare reform bill. It is not a welfare reform bill. Unfortunately, through the process, as it often happens when legislation moves through this body, the Finance Committee, without having hearings, faced an amendment that came up and it became a part of the bill that is on the Senate floor today. It would provide benefits not to American citizens but to non-citizens. It

would amend the law that was passed some time ago prohibiting such actions.

So I have sent to the desk an amendment which would strike section 605 of the bill, the section that allows Medicaid and State health insurance program coverage to be given to noncitizens, and insert a sense of the Senate that this section should be referred back to the Finance Committee.

In 1996, with a vote of 74 to 24, this body made a principled, purposeful decision during reform of welfare in this country, that non-citizens should not access Federal programs such as TANF and Medicaid for the first 5 years they are in the United States. That is because these costs are supposed to be incurred by the sponsors of those people who come into the United States. That is why we make the sponsor of an immigrant who comes into the United States lawfully sign an affidavit that they will be responsible for that person's health care benefit. Of those Senators who are still in service in this body, 45 voted for it. That is quite a significant number.

Section 605 would lift the 5-year ban for pregnant women, and children, from fiscal year 2005 through fiscal year 2007. In other words, we would allow pregnant women and children who have sponsors in the United States to access the welfare system of America to pay for their health care, contrary to the fully debated and wisely established rule in 1996 not to do that.

The President is concerned about that. The administration is opposed to this change. They note that the administration has proposed substantial new flexibility on the part of Medicaid and SCHIP reform, and coverage for legal immigrants should be examined as part of this context.

So we will be examining Medicaid, the SCHIP program, and Medicare reform later this year. That is the time we should be discussing changing our current policy as to what benefits are available to noncitizens, not slipping it through as part of this important bill.

This is not a decision that we should change, not a policy that ought to be altered, without some significant study and debate. We are amending the welfare reform bill as part of a prescription drug bill. This is a major policy shift. It ought not to be added in this fashion. This bill is for America's senior citizens, not for non-citizens. If we want to make such important changes in funding eligibility and criteria for these programs, we ought to be ready to have a full and open debate on welfare policy. That is the kind of debate we had in 1996. I think some good decisions were made then that helped this country tremendously. It helped poor families move from welfare to work and did a lot of things for children in this country.

The Finance Committee, which added section 605, should have hearings and go about it as part of the welfare reform bill. I feel strongly about that.

Before 1996, the cost of welfare for immigrants had skyrocketed in America to $8 billion a year. That was in 1996. Harvard economist George Borjas found that immigrant households were 50 percent more likely to use Federal welfare programs than were citizen households. So this was the untenable position and situation in 1996, and that is what was ended by the legislation then.

In 1996, Congress dealt specifically with the issue of welfare and immigration. In an overwhelming manner they passed the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 which was signed by President Clinton and became law.

The 1996 welfare and immigration reforms significantly restricted participation of new immigrants in Federal means-tested poverty programs and dramatically curtailed the access of permanent resident aliens to Federal welfare programs. That was exactly our goal. The 1996 reform strengthened the welfare system and made more funds available for citizens in need. In passing this law in 1996, this Senate specifically stated certain national policy concerns related to welfare and immigration that should not be changed haphazardly.

They said self-sufficiency has been a basic principle of United States immigration law since this country's earliest immigration status. Self-sufficiency is a key part of our whole concept of immigration.

It continues to be the immigration policy of the United States that:

(A) Aliens within the Nation's borders not depend on public resources to meet their needs, but rather rely on their own capabilities and the resources of their families, their sponsors, and private organizations, and the availability of public benefits not constitute an incentive for immigration to the United States.

Despite the principle of self-sufficiency, aliens have been applying for and receiving public benefits from Federal, State, and local governments at increasing rates.

It is a compelling government interest to enact new rules for eligibility and sponsorship agreements in order to assure that aliens be self-reliant in accordance with national immigration policy.

It is a compelling government interest to remove the incentive for illegal immigration provided by the availability of public benefits.

That is what we are talking about. That sums it up. That was a thoughtful policy and change made in 1996. We ought not to have it slip through here on this important bill today without full hearings and discussion.

Section 605, which now in this bill, would repeal the general prohibition of nonqualified aliens being eligible for any Federal public benefits, as it applies to protect women and children, even though ample exceptions for certain public benefits are already provided, such as emergency medical assistance. That is available now. Short-term disaster relief. Immunization, housing, and communities development assistance, and any assistance specified by the Attorney General.

Section 605 waives the 5-year waiting period before immigrants are allowed to receive Federal benefits, thus creating a huge incentive for the benefited class of citizens to rush the borders for instant care. A person who has the possibility of coming to this country, has considered it and decided not to, if their child has a health problem, would not they, therefore, be incentivized to try to come across this border, knowing they could apply for and have public benefit of the United States?

And we would like to do that. Do we do that for the entire world? It is just not possible. It is not good public policy. A nation has to have policy that is rational and defensible.

A wide range of Federal programs are exempted from this requirement, including emergency Medicaid, certain immunizations, short-term disaster relief, school lunch programs, the WIC program, foster care, adoptive assistance, and Head Start. Those are available now.

Section 605 will dissolve the financial accountability requirement of the sponsor. If section 605 passes, sponsors will no longer be held responsible to the Government for the cost of the Federal means-tested benefits to the aliens they sponsor.

The Illegal Immigration Reform and Immigrant Responsibility Act of 1996, coupled with the 1996 welfare reform law, purposefully altered the obligations of persons whose sponsored immigrants arrived or are adjusting status in the United States.

In 1996, as part of the immigration reform, we required that affidavit of support be rewritten as a legally binding contract, enforceable against the sponsor through the time the sponsor immigrant becomes a citizen or has contributed to Social Security for 10 years. Affidavits of support are intended to implement the provisions of the INA that excludes aliens who appear ''likely at any time to become a public charge.'' No nation accepts people into their country who are likely to be a public charge of the country. A nation accepts people who are going to be contributors and will benefit that society.

This is consistent with the recommendation of the Commission on Immigration Reform. In a report to Congress the commission stated sponsors of immigrants should be held financially responsible for the immigrants they bring into this country.

Under the INA code a sponsor is defined as a person who is a citizen, national or lawfully admitted, of the United States, 18 years of age, lives in the United States and demonstrates the means to financially maintain a sponsorship. They can petition the Federal Government through an affidavit of support for the admittance of an individual residing outside the United States.

In other words, a sponsor has to be a person who has the means to financially maintain a sponsorship. If they

cannot sign that affidavit honestly, then the person should not be admitted into the country. The sponsor requirement allows for the admission of any person into the United States who is unable to take care of himself or herself without becoming a charge to the taxpayers by assuring, via affidavit, that the sponsor will financially support the person.

An affidavit for support may not be accepted unless the sponsor agrees to, one, provide financial support to maintain the sponsored alien; two, be legally bound to the Federal Government of any entity that provides any means-tested public benefit which includes Medicaid; and three, submit to the jurisdiction of any Federal court.

If a sponsored alien received any means-tested public benefits, the entity which provided such benefits can request to be reimbursed by the sponsor, and if reimbursement is not satisfied, then the sponsor will face civil penalty.

Under this proposed legislation, the sponsors of these new immigrants would be absolved from their liability under the program. Aliens will no longer be supported and maintained by their sponsors and would become a charge on the public once again, a problem we sought to and did remedy in 1996.

As we finish here tonight, we have a lot of important matters involved in this legislation, involving a lot of money. CBO estimates that this provision would cost half a billion over three years. It spends that money by changing what I think to be a good policy by creating a bad policy, a policy that will incentivize people to come to the United States for free health care when they may not otherwise wish to come or may not otherwise benefit from coming here. We really have not had the kind of debate, as a comprehensive review of welfare, that should be made a part of that.

The Finance Committee will be considering welfare reform. It will be considering these issues in the months to come. They have a lot on their plate.

This amendment simply says let's not rush this through now. Let's not move it through on this important bill that is going to move through Congress. Let's send it back to the Finance Committee. Let's encourage them to give thoughtful and serious concern to it. Let's have them come forward with a program that would justify us changing this important rule, established in 1996.

I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa.

MEXICAN BARRIERS TO IMPORTS OF U.S. AGRICULTURAL PRODUCTS

Mr. GRASSLEY. Mr. President, it has been almost 10 years since the North American Free Trade Agreement—NAFTA—went into effect. Overall, this agreement has been a great success for America's farmers and ranchers. Between 1994 and 2002, U.S. Agricultural exports to Mexico grew by 95 percent.

Mexican agriculture has benefited as well from NAFTA. Exports of Mexican agricultural products to the United States increased by almost 97 percent from 1993 to 2001. At the present time, some 78 percent of all agricultural products exported by Mexico are sent to the United States, making the United States by far the largest market for Mexico's agricultural exports. Clearly, the agricultural sectors of both the United States and Mexico have on the whole profited from NAFTA. For this reason, I am confounded by some of the recent actions of the Mexican government that undermine the spirit, if not the letter, of NAFTA.

Allow me to elaborate on some of these actions. Mexico has recently imposed, or threatened to impose, trade barriers to a wide variety of U.S. agricultural products. These products include pork, beef, corn, high fructose corn syrup, rice, apples, and dry beans. Apparently ignoring that increased competition in the Mexican market has benefited that country's consumers, some in Mexico have spoken of renegotiating the agriculture provisions of the NAFTA. Mexico's measures against U.S. agricultural products have certainly caught the attention of many members of the Senate, including me.

Let me explain Mexico's actions that are directly impacting producers in my state of Iowa.

I'll start with high fructose corn syrup. It's true that U.S. producers of agricultural products have, on the whole, benefited from NAFTA. And, at one point, that was the case with U.S. producers of high fructose corn syrup. Mexico was formerly the largest export market for U.S. produced high fructose corn syrup. But in January 2002, the Mexican Congress imposed a tax of up to 20 percent on soft drinks containing high fructose corn syrup.

This move was undoubtedly intended to provide Mexican sugar producers with an unfair advantage in the Mexican market over U.S. high fructose corn syrup producers. As a result of this discriminatory tax, U.S. exports of high fructose corn syrup to Mexico are now at almost zero levels.

Mexico's high fructose corn syrup tax was imposed following WTO and NAFTA panel rulings that found that a 1998 Mexican antidumping order on U.S. high fructose corn syrup did not comply with Mexico's trade obligations.

Clearly, Mexico is going out of its way to prevent the sale of high fructose corn syrup in its market. Mexico's high fructose corn syrup tax is causing great harm to U.S. corn producers and U.S. high fructose corn syrup manufacturers. The U.S. corn refining industry estimates that it is losing up to $620 million annually on account of Mexico's discriminatory tax. It estimates that U.S. corn farmers are losing over $300 million each year due to lost sales to both U.S. and Mexican high fructose corn syrup producers.

I find it especially ironic that Mexico, a country that is actively seeking foreign investment, is treating so poorly the U.S. high fructose corn syrup industry, an industry that has invested heavily in Mexico.

Based upon the promises of NAFTA, U.S. high fructose corn syrup producers made major investments in the United States and Mexico. Mexico has now pulled the rug out from under them. This certainly sends, at best, mixed signals to foreign investors.

Let me give you another example of Mexico's actions against U.S. agricultural products, this one impacting Iowa's pork producers. In January of this year, Mexico initiated an antidumping investigation on U.S.-produced pork. The petition that initiated this investigation has serious deficiencies. for example, the petition was filed by Mexican hog producers, not pork processors, so it is my understanding that the party bringing the case lacks standing under the Antidumping Agreement of the WTO.

While Mexico's antidumping investigation on pork is ongoing, I recognize that Mexican officials last month terminated the Mexican antidumping order on imports of live hogs from the United States. I am pleased with Mexico's decision regarding the live hog order. I strongly hope that this decision provides an indication that Mexican officials will act reasonably and not impose an antidumping order on U.S. pork.

But there are other problems. Large quantities of U.S.-produced pork have been rejected at the Mexican borer during the past year due to alleged sanitary problems. But millions of Americans consume U.S.-produced pork each day, and we know that this product is safe. Mexico's rejection of U.S. pork for non-scientific reasons violates Mexico's WTO obligations.

Iowa's beef producers are also being harmed by Mexico's actions. In April 2000, Mexico imposed antidumping duties on imports of U.S. beef, and this trade measure remains in place. Mexico's investigation resulted in numerous probable violations of Mexico's commitments under the WTO Agreements. On June 16, the U.S. Trade Representative announced that the United States is filing a case at the WTO over Mexico's antidumping order. I fully support the U.S. trade Representatives's actions at the WTO regarding this matter.

Despite the ongoing Mexican antidumping order on U.S. beef, Mexican cattle producers earlier this year filed a safeguard petition on beef from the United States.

Mexican officials have neither confirmed nor denied the existence of this petition. Lack of certainty with regard to this safeguard petition has made it even more difficult for the U.S. cattle and beef industry to plan sales in Mexico.

White corn producers in Iowa are also threatened by potential Mexican trade actions. Mexican officials are hinting at initiating a safeguard investigation on imports of U.S. white corn. In addition, these officials have suggested limiting import permits for white corn for periods of short supply. Such a policy would not comport with Mexico's NAFTA obligations.

Mexico's actions, and threatened actions, against U.S. agricultural products such as high fructose corn syrup, pork, beef, and white corn are having real effects on U.S. producers. Sales in Mexico are being lost or threatened. Uncertainty is making it difficult for U.S. producers to plan for future sales in Mexico.

But Mexico's actions are having a broader effect than lost sales. Mexico's policies are indirectly threatening the entire U.S. trade agenda.

Most of U.S. agriculture was solidly behind the passage of the NAFTA. But with Mexico failing to abide fully with its NAFTA commitments, many U.S. producers are beginning to question the worth of trade agreements.

If America's farmers and ranchers back away from their strong support for new trade agreements, the U.S. trade agenda will lose its biggest proponents. And if the United States falters in its support for trade liberalization, the whole world will suffer.

Given the importance of maintaining the U.S. trade agenda, I urge the administration to make the removal of Mexican barriers to U.S. agricultural products a top priority. The U.S. Government must not overlook systematic efforts by Mexico to keep U.S. farm products out of the Mexican market in disregard of Mexico's international trade commitments.

Finally, I urge Mexican officials to think twice about the effects of their decisions involving U.S. agricultural products. Mexico's actions are threatening that country's trade relations with its largest export market. Damaged trade relations between the United States and Mexico are certainly not in the best interests of either country.

NAFTA can, and will, continue to provide great benefits to farmers, ranchers, and consumers on either side of the border. But this trade agreement will work only if all parties to it abide by their NAFTA commitments.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Mr. President, I ask unanimous consent to be recognized as in morning business.

The PRESIDING OFFICER. Without objection, it is so ordered.

IMMIGRATION AND DRUG COSTS

Mr. DURBIN. Mr. President, one of the most fascinating aspects of this job in the Senate is the myriad of issues that come before us in the course of a day or week. If you followed over the last few moments the two speakers—one from Alabama and one from Iowa—they both were speaking about related issues.

My friend from Iowa and I share an interest in agriculture. His State and mine lead the Nation in the production of corn and soybeans, and naturally we try to export our goods to expand our trade. And he is concerned—and I share his concern—about Mexico. We both voted for the North American Free Trade Agreement in the belief of opening up—and it has opened up—trade substantially between these two neighboring countries, the United States and Mexico. But we have run into some problems here, problems related to corn, as my colleague from Iowa noted, whether we can export white corn to Mexico, which, of course, is a major staple of their diet, being the basis for tortillas, part of the Mexican cuisine, and also whether we can export a product made from corn called high fructose sweetener.

For people who may not be familiar with that term, trust me, virtually every soft drink that you consume in America has high fructose sweetener in it rather than sugar. We want to sell it in Mexico, and they do not want us to sell it there. Frankly, they want to export more sugar to the United States.

So this trade battle is on. The Senator from Iowa is right, this has been going on too long, and it has to come to an end.

I would say to our friends in Mexico—and they are our friends and allies and neighbors—we have to resolve this.

We have to resolve it equitably and honorably, but it has to be done with dispatch. So I certainly support what the Senator from Iowa said.

Now, before he spoke, the Senator from Alabama got up to speak about immigration. And here is the story, as I see it, related to this trade issue.

If the farmers in Mexico—who are struggling to grow their crops, with much less efficiency and productivity than the farmers in the United States—are unsuccessful in their farms, many of them move to the city. It is very common. It happens throughout the developing countries of the world. If they move to the large cities in Mexico and they cannot find a way to sustain their families, there is an alternative: El Norte. They head north. And we have seen a dramatic migration from Mexico to the United States.

In the last 10 years, my State of Illinois has seen a substantial increase in the Mexican-American population. I know it; I see it; I feel it. It is now part of our life in Illinois. The people who have come here I have found overwhelmingly to be some of the finest people I have ever had a chance to meet. It takes real courage to get up and leave your village, your family, your church, your language, your tradition, and to head thousands of miles north into the bitter cold, trying to find a job, to make enough money to sustain yourself and maybe sending back some money to your family in Mexico. Thousands have done it. Many have done it undocumented and illegally, and that is another issue.

I will say, it is naive for us to believe these undocumented immigrants to the United States have not become an integral part of our economy. They are. A leading restaurateur in Chicago said to me: If you removed all of the undocumented people from the restaurants of this great city, you would have to close them down. Every time you turn around and see who is washing the dishes, busing the tables, doing the work—some of the hardest work in my State and others—you will find a lot of people who are here perhaps without legal documentation.

A few minutes ago, the Senator from Alabama said he objected to a provision in the bill we have been debating, S. 1, the prescription drug bill, because this provision says that those women who are legally in the United States—legally in the United States—would be able to qualify for Medicaid coverage and their children for basic health insurance coverage if a State decided to offer that coverage.

That is what the bill says. So if the State of Missouri or the State of Illinois or Iowa or Alabama says: We are not interested in offering Medicaid coverage to legal immigrants who have not been here 5 years—legal immigrant women—then they do not have to. Twenty States have decided, though, it makes good sense to go ahead and enroll these legal immigrant women and their children into Medicaid at their own expense.

Why would a State Governor and legislature decide to pick up and cover these people? Well, for obvious reasons. Women who come to this country in a legal immigrant status often become pregnant and during the course of that pregnancy need prenatal care. If they do not receive prenatal care during their pregnancy they could end up with complications in the pregnancy or some serious illness facing the child.

Now, Governors and legislatures have said it is far better for us to offer prenatal care to that legal immigrant woman and her child, once born, than to run the risk they are going to be unhealthy, not only for their own sakes but for the cost it would bring to society. I think that is perfectly sensible.

The Senator from Alabama objects. He says we should not give States the option to provide, with Federal assistance, that kind of medical care. I think that is a mistake. I think the bill is right. The bill understands that these women, during their pregnancy, are carrying future American citizens. Those babies, once born on our soil, are citizens.

Is it important for us to make sure—or do the best we can to make sure—those mothers are healthy and the babies are healthy. Well, if not for the sake of humanity, certainly from an economic point of view it is. A sick baby is not only a family tragedy, it becomes a social cost. So this bill, by giving to States the option of offering Medicaid to legal immigrant women and health insurance to their children,

once born, I think just makes common sense.

It will be interesting to watch the vote tomorrow to see how many Senators in this Chamber, who feel very strongly about the so-called pro-life position, who want to make certain that we avoid abortions and that we honor the children who are being born, join the Senator from Alabama in denying prenatal care to legal immigrant women and denying their babies, once born, health insurance.

I would think it is obvious, whatever your position on the issue of abortion, that if you believe in families, you would vote against the amendment by the Senator from Alabama.

Let me just say very briefly, when I was a young student, I read a Sherlock Holmes book that I still remember. It was entitled ''The Dog That Didn't Bark.'' Sherlock Holmes solved this mystery by not hearing something but by realizing that he hadn't heard something. The witnesses to this crime had not heard a dog bark. And that was an important piece of evidence for him to determine what happened that led up to the actual murder.

The reason I remembered that is I am listening carefully to this national debate on the floor of the Senate about a prescription drug bill. I am waiting for the barking of the pharmaceutical lobby. Where are the drug companies? Why haven't we heard from the drug companies?

This is a bill that will affect some 40 million senior citizens and provide assistance for them to pay their prescription drug bills, and the drug companies are silent. Why? There are two reasons for it.

First, they believe the passage of a Federal prescription drug benefit is going to reduce the likelihood that more and more States will establish their own State prescription drug plans, bringing down the cost of prescription drugs in each State. I commend to those who follow it a ''Frontline'' program of last week on public television that analyzed this.

As the States of Maine and Oregon and my State of Illinois and others developed prescription drug plans, the pharmaceutical industry challenged them in court, particularly in the case of Maine, and lost the challenge.

So it was at that point that they became more intent on seeing us pass a prescription drug benefit on a national level to try to diffuse this growing public sentiment against increasing drug prices and the growing public sentiment that local and State legislatures had to act on this because the Congress was inept, unable to do it.

So we have this bill before us that is one of the reasons why the pharmaceutical lobby has been strangely silent during this debate. They are happy that we are considering a Federal prescription drug benefit program.

The second reason is even more important. This bill, S. 1, before us now for consideration, is a pretty long bill. As a matter of fact, it is 654 pages long. You will have to search this bill line by line and page by page and I am afraid you will find that after that search, there are few, if any, efforts in this entire bill to control the runaway cost of prescription drugs. So the pharmaceutical companies see this as a win/win situation. We pass a national prescription drug program that takes the heat off the States, and at the same time we do nothing to reduce the cost of prescription drugs to seniors and others across America. So these already very successful companies have to view this as the greatest windfall that has ever come their way.

The Federal Government will pay a percentage of the cost of prescription drugs, but the Federal Government will do little or nothing to control the cost of those drugs.

The senior citizens of this country understand this issue far better than Members of the Senate. In fact, when they were recently asked the question: What is more important to you, to provide a prescription drug benefit under Medicare to help you pay for your prescription drugs or to establish a policy and program that will bring down the excessive costs and the increasing rise in cost of prescription drugs across the Nation, by a margin of almost 2 to 1, they said go after the cost of the drugs. Don't tell me how much you are going to give me if you are not going to control the cost.

Last year, the cost of prescription drugs went up 10 percent in my State of Illinois. Nationally, the figures are higher. If those increases continue, no matter what we pass this week in the Senate, it will not be enough. The cost of drugs will go off the end of the chart, and private insurance companies, HMOs that are being lauded by conservatives, by the President, and the White House as the answer to our prayers, frankly, don't have the interest or the power to make a difference in the cost of these prescription drugs. So the seniors will find themselves at the end of the day with a very limited benefit from this program.

But hope is on the way. Tomorrow I will be offering an amendment which is a dramatically different approach to dealing with prescription drugs. We are going to make cost containment part of our prescription drug program. We are going to follow the model of the Veterans' Administration which said, in serving the millions of America's veterans, drug companies had to give a discount to the Veterans' Administration on the drugs that were provided, and the drug companies did—a discount of 40 to 50 percent. This isn't radical or innovative. It is a fact. This is what is happening.

We believe using the same logic and the same Government effort to bring competition and lower costs under my amendment will mean that drug costs will start coming down and this program will go a lot further in helping seniors. And once the drug costs start coming down, let me tell you what we can do: This bill does not guarantee a monthly premium for prescription drug benefits. It suggests $35 a month. But I think the sponsors will tell you, there is no guarantee that it won't be $50 or $75 a month for this prescription drug program being offered by HMOs and private insurance companies under the Grassley-Baucus bill.

Under MediSAVE, which is my alternative plan, we mandate a $35-a-month maximum monthly premium. Second, there is a $275 deductible before anybody can get the first dollar in Government benefits under the Grassley-Baucus bill. Under the amendment I will offer, there is no deductible. Third, under the Grassley-Baucus bill, they will pay 50 percent of the cost of prescription drugs after the deductible is applied. Under the MediSAVE Program, which I am going to introduce, it is 70 percent.

How can I offer all this? How can I offer a program that has no gap in coverage so that it continues to cover you right up to a $5,000 annual cost in drugs and then you switch over to catastrophic coverage? How can I do all this? Because I go after the price of the drugs. The underlying bill doesn't touch the cost of drugs. As a result, $400 billion, as large a sum as that may sound, does not go very far. When we bring in cost containment, we can offer a real prescription drug program.

And there is one more thing. The amendment I will offer will allow Medicare itself to compete with the private insurance companies. I have listened carefully to the debate for the last week or so. I can tell you that most of my Republican friends are loathe to concede the obvious. There is no private insurance company that can effectively compete with Medicare when it comes to offering prescription drug benefits. Why? Because Medicare doesn't have a profit motive. Medicare has a low overhead. Medicare can bargain on behalf of millions of seniors to get a formulary or a list of drugs at discount prices.

These private insurance companies cannot do any of those things. They are out for the profit. They have high administrative costs, and they won't have the power to bargain down the price of the cost of the drugs. So by putting Medicare in the mix, saying every senior can always turn to the Medicare prescription drug program, we have real choice and real competition and a real scare for the Republicans who believe that competition only involves private insurance companies. They don't want a Government agency competing with them.

The amendment I will offer tomorrow has been endorsed by a number of my colleagues on this side of the aisle, as well as the AFL-CIO, the United Auto Workers, a variety of unions across the United States, as well as senior citizens organizations. They understand this is a real prescription drug benefit program that tries to keep the costs

under control and makes sure we maximize the benefits to seniors across the United States.

It will be interesting to note the vote tomorrow. I believe there have been clear indications that many people here are not going to do anything to ruffle the feathers of the drug companies and pharmaceutical lobby. I hope they will keep in mind that the senior citizens they represent understand full well that these drug companies are the most profitable companies in America.

They can bring down costs. They have done it in Canada and in other countries. They can still make enough profit to reward shareholders for their risk and have money left to invest in research. I hope this MediSAVE amendment will have the positive response of my colleagues tomorrow when it is offered on the floor.

I am prepared to yield the floor at this time, and I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. FRIST. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003—Continued

Mr. FRIST. Mr. President, as we bring this very busy day to a close, I wish to reflect on where we are with this very historic bill that will provide prescription drugs and, at the same time, strengthen and improve Medicare for our seniors and individuals with disabilities.

It is a historic week in many ways, but primarily because we will accomplish something that many thought would be impossible even a couple of months ago that will benefit America's seniors; historic because during this week, both Houses will likely pass the first major reform of Medicare in the almost 40 years of that program's existence.

Thanks to the strong leadership of President Bush, as well as the bipartisan support of this body, I am optimistic that by the end of this week, we will have added a $400 billion prescription drug benefit for our deserving seniors for their health care security. And indeed, it has been a long time in coming. A lot of us have talked about it, have known we should move in that direction, and now after a lot of participation we will be able to deliver on that for which we have all worked so hard. Both parties have promised action in the past. America's seniors have demanded it. Indeed, America's seniors deserve it.

As part of this current legislation, not a lot has been said on this particular aspect of it, so I do want to mention it. Within 8 months or 9 months after the President signs the final product of our discussions, when he signs this bill, seniors will have access to a prescription drug card that will provide immediate savings for them. This is an important interim move that allows us to say to seniors: Help is, indeed, on the way.

During this period of time of a year and a half or a couple years while they have that prescription drug card, we will be constructing the appropriate infrastructure to provide that prescription drug benefit for that population that wishes to stay in traditional Medicare or that population that wishes to take advantage of a new, transformed type of Medicare that will allow continuous, ongoing quality care in a more seamless fashion, a fashion that will involve preventive medicine and chronic disease management, as well as prescription drugs.

The great aspect about what we are doing, at the same time we are offering this new benefit of prescription drugs, which our seniors deserve, is that we are modernizing the Medicare Program, strengthening it, improving it in a way that can be sustained long term, and hopefully there will even be some cost savings in the future, but at the same time I am absolutely positively sure that the quality of care will be better. I say that because of this focus on preventive medicine, chronic disease management, and overall disease management which is simply not provided in traditional Medicare.

I wish to list a couple of principles.

First, individual choice versus a one-size-fits-all system. Seniors, for the first time, will be given an opportunity to choose the health care coverage which will best meet their individual needs. It is very different from the one-size-fits-all type program that is provided today.

Second, private sector competition versus Government price setting. Private insurers—I mention private insurers and private plans because we hear a lot today from certain think tanks that not very much is new in this bill. There is not very much reform, there is not very much modernization.

My simple response to them is, yes, there is a new entitlement in terms of this drug benefit, but it is going to be delivered 100 percent through the private sector, through private plans. Yes, regulated by Government, but the entities, the mechanisms of delivering these prescription drugs, whether it is in a freestanding plan or part of the traditional Medicare+Choice or part of a new PPO system, are 100 percent competitively bid with market-based principles.

That allows us to step back and say: Yes, there is something new that over the long haul, if carried out well, if appropriately structured, will allow seniors to have better value, a higher quality of care for the same input, the same amount of money that is spent.

So this market-based competition is important and, I would argue, is very important to the long-term sustainability of the program because of this huge demographic shift of the doubling of the number of seniors.

Third, innovation versus bureaucratic delays. The participation of private health plans in Medicare will help ensure up-to-date coverage. Because Medicare is so rigid, it takes a long time for Medicare to incorporate innovation, new technology, new and better ways of doing things. When you have Government bureaucrats making the decisions or politicians or political figures deciding what is covered and what is not, it simply takes a longer time than occurs in the more responsive private sector.

Four, long-term savings versus spiraling costs. There is a lot of debate in this Chamber, but I would argue, consistent with what the Medicare actuaries tell us, that the most efficient private plans today have the potential for beating Medicare costs by as much as 2.3 percent. Compounded over time, that can result in significant cost savings to the program. Thus, for the same input of dollars, you will have better output, better care delivered, and better quality of care.

The final point I will close with is regulatory relief versus the redtape of bureaucracy that is so characteristic of our Medicare system today. In this bill, there are several rulemaking and regulatory relief changes for health care providers that will allow them to focus on what they should be doing; that is, providing that clinical care, that patient care, instead of filling out paperwork or spending a lot of time on redtape activity.

A recent study by Price Waterhouse estimated that for every hour in the emergency room, there are about 30 minutes of paperwork required by emergency personnel. There is just no reason for that today, and this bill helps address that regulatory relief.

So a new benefit, individual choice, market-based competition, rapid assimilation of new technology, as well as new medicines, long-term savings, relief from this red tape, health security for seniors, that is what this bill is all about.

VOTE EXPLANATION

Mr. BROWNBACK. Mr. President, I regret that due to a previously scheduled White House event celebrating Black Music History Month, I was unable to cast a vote on Amendment No. 1002 offered by my friend, Mr. LAUTENBERG. I would like the RECORD to reflect that had I been present, I would have voted against the amendment.

Mr. JOHNSON. Mr. President, as we move forward with debate on Medicare prescription drugs, it is important to recognize that this bill does very little to address the unrestrained costs of prescription drugs. I find it disconcerting that as we are discussing one of the most major public program expansions of all time, we have neglected to have a real discussion about how to ensure that taxpayers get the

most bang for their buck in this program, and that seniors who will have significant cost sharing responsibilities have as minimal a burden as possible.

For many years, I have been a strong advocate for implementing reforms to reduce prescription drug costs for consumers in this country. I believe one way to do that is through increasing consumers' access to approved, safe and affordable generic prescription drugs. Last week the Senate passed an amendment that would accomplish this very goal. I was pleased to see that the Gregg-Schumer-McCain-Kennedy amendment passed the Senate with wide bipartisan support and I want to thank my colleagues for their dedication and hard work on this issue. This represents one encouraging step towards leveling the playing field and ensuring that prescription drug costs under this program are indeed reasonable.

The generics amendment, which I have cosponsored along with many of my colleagues will allow generic drug companies to compete with brand-name manufactures by clearing the major obstacles that delay generic drug approval. The act levels the playing field for generic drug makers to better compete against large, brand-name manufacturers, and it represents a bold step in putting consumer health and savings first. The legislation seeks to bolster the Hatch-Waxman Act passed in 1984, which promoted the growth of the generic drug industry. Loopholes in the patent laws, which benefited brand-name drug manufacturers, prohibited the bill from ever realizing its full potential.

Efforts to promote the value of generic drugs are competing with some powerful forces, such as direct-to-consumer advertising and the unwillingness of many doctors to prescribe generic drugs more regularly. However, I believe this amendment, along with greater public education efforts directed at consumers and doctors about the effectiveness of safe and approved generic drugs, will go a long way towards improving greater access and utilization of generic prescription drugs.

I will continue to fight for lower prescription drug costs and will oppose any efforts that would deny generic drugs equal access into the market. With the enactment of this amendment, we are one major step closer to achieving this goal and I hope the House will follow suit and make similar provisions a part of shier Medicare prescription drug legislation. Passage of the generics amendment paved the way, but we must not stop here. We must continue the discussion and debate on the cost containment of prescription drugs under this program and I urge my colleagues to support all amendments that work towards that goal.

Mr. SMITH. Mr. President, I would like to join my distinguished colleague from Iowa as a cosponsor of the ''Money Follows the Person Amendment'' to the Prescription Drug and Medicare Improvement Act of 2003.

This amendment would authorize the 2004 ''Money Follows the Person'' initiative in Medicaid, a part of the President's New Freedom Initiative to integrate people with disabilities into the communities where they live.

This amendment would create a 5-year program to help States move people with disabilities out of institutional settings and into their communities. For example, under this legislation, Oregon's effort to help an individual move out of an institutional care facility and into a community home would be 100 percent federally funded for 1 year. After that first year, the Federal Government would pay its usual rate. Under the provisions of this amendment, States like Oregon can take advantage of $350 million dollars of Federal assistance for 5 years for a total of $1.75 billion.

This amendment is important to the disabled community for several reasons. First, by supporting States' efforts to help Americans who have been needlessly placed in institutional settings move into community settings, this amendment will help States increase access to home and community-based support for people with disabilities.

Second, by assisting the movement of people who are not best served by an institution into a community care facility, this amendment gives them the freedom to make choices. Too often, Americans with disabilities are unable to take advantage of opportunities others take for granted—to choose where they want to live, when to visit family and friends, and to be active members of their communities.

Finally, this amendment would help States comply with the Americans with Disabilities Act. As my colleagues in the Senate are well aware, we are nearing the 13th anniversary of the Americans with Disabilities Act and of the Olmstead Supreme Court decision. That decision ruled that needless institutionalization of Americans with disabilities constitutes discrimination under the Americans with Disabilities Act.

I urge my colleagues on both sides of the aisle to support this important amendment and to support the freedom of choice for Americans with disabilities.

AMENDMENT NO. 974

Mr. LEAHY. Mr. President, last November, the Drug Competition Act passed the Senate by unanimous consent. This morning, I am proud to join Senator GRASSLEY, along with Senators CANTWELL, DURBIN, FEINGOLD, KOHL, and SCHUMER in offering our bill as an amendment to the Prescription Drug and Medicare Improvement Act of 2003, S. 1, I hope that in this Congress it is actually enacted into law as part of the larger effort to improve the health care of millions of Americans. Prescription drug prices are rapidly increasing, and are a source of considerable concern to many Americans, especially senior citizens and families. Generic drug prices can be as much as 80 percent lower than the comparable brand-name version.

While the Drug Competition Act is small in terms of length, it is large in terms of impact. It will ensure that law enforcement agencies can take quick and decisive action against companies that are driven more by greed than by good sense. It gives the Federal Trade Commission and the Justice Department access to information about secret deals between drug companies that keep generic drugs off the market. This is a practice that hurts American families, particularly senior citizens, by denying them access to low-cost generic drugs, and further inflating medical costs.

Last fall, the Federal Trade Commission released a comprehensive report on barriers to the entry of generic drugs into the pharmaceutical marketplace. The FTC had two recommendations to improve the current situation and to close the loopholes in the law that allow drug manufacturers to manipulate the timing of generics' introduction to the market. One of those recommendations was simply to enact our bill, as the most effective solution to the problem of ''sweetheart'' deals between brand name and generic drug manufacturers that keep generic drugs off the market, thus depriving consumers of the benefits of quality drugs at lower prices. Indeed, at a hearing just yesterday in the Judiciary Committee, Chairman Timothy Muris of the FTC praised the Drug Competition Act in his testimony, and urged its passage. In short, this bill enjoys the unqualified endorsement of the current FTC, which follows on the support by the Clinton administration's FTC during the initial stages of our formulation of this bill. We can all have every confidence in the common sense approach that our bill takes to ensuring that our law enforcement agencies have the information they need to take quick action, if necessary, to protect consumers from drug companies that abuse the law.

Under current law, the first generic manufacturer that gets permission to sell a generic drug before the patent on the brand-name drug expires enjoys protection from competition for 180 days—a head start on other generic companies. That was a good idea—but the unfortunate loophole exploited by a few is that secret deals can be made that allow the manufacturer of the generic drug to claim the 180-day grace period—to block other generic drugs from entering the market—while, at the same time, getting paid by the brand-name manufacturer not to sell the generic drug.

Our legislation closes this loophole for those who want to cheat the public but keeps the system the same for companies engaged in true competition. I think it is important for Congress not to overreact and throw out

the good with the bad. Most generic companies want to take advantage of this 180-day provision and deliver quality generic drugs at much lower costs for consumers. We should not eliminate the incentive for them. Instead, we should let the FTC and Justice look at every deal that could lead to abuse, so that only the deals that are consistent with the intent of that law will be allowed to stand. The Drug Competition Act accomplishes precisely that goal, and helps ensure effective and timely access to generic pharmaceuticals that can lower the cost of prescription drugs for seniors, for families, and for all of us.

The effects of this amendment will only benefit the effort to bring quality health care at lower costs to more of our citizens. The Drug Competition Act enjoyed the unqualified support of the Senate last year, and I hope my colleagues will recognize that it fits well within the framework of the Prescription Drug and Medicare Improvement Act of 2003. It will do nothing to disrupt the balance struck in the larger bill, while aiding the ultimate goal of that legislation. I urge all Senators to embrace this effort on behalf of Medicare recipients, and of all Americans.

MORNING BUSINESS

Mr. FRIST. Mr. President, I ask unanimous consent that the Senate now proceed to a period for morning business.

The PRESIDING OFFICER. Without objection, it is so ordered.

TRIBUTE TO MAYNARD JACKSON

Mr. MILLER. Mr. President, I rise this evening to pay tribute to one of Georgia's finest, one of this Nation's finest. I pay tribute to the life and legacy of former mayor of Atlanta, Maynard Jackson. In a city known for its great civil rights leaders, Maynard Jackson was truly one of the greatest. The people of Atlanta and Georgia have lost one of our strongest and most articulate fighters. Indeed, the State of Georgia tonight is mourning the passing of one of our greatest citizens.

Maynard Jackson was such a positive presence in all that has happened in Atlanta and in Georgia over the past 30 years that I simply cannot imagine what our city and our State would be like if he had not come our way.

His impact stretched far beyond the red clay hills of Georgia. He touched the lives of many people all around this world. For me, Maynard Jackson was a good friend, a friend whose counsel I always sought because I knew he would give it to me straight. In Atlanta the City Hall and the State Capitol are right across the street from each other. He and I crossed that street to talk on many occasions.

Maynard's rise to prominence began at an early age. As a child prodigy he entered Morehouse College at age 14. He graduated in 1956 with a bachelor's degree of political science and history. In 1964 he graduated from North Carolina Central University Law School. Maynard then returned to Atlanta as an attorney for the National Labor Relations Board followed by a time at the Emory Community Legal Services Center where he provided legal counsel for low-income Atlantans.

He ran for the Senate in 1968 and lost. But we all knew at that time the world would come to know the voice of this very remarkable, articulate, and passionate young man. In 1973, at the age of 35, he became mayor of Atlanta after winning nearly 60 percent of the vote in a runoff against incumbent mayor Sam Massell. This great-grandson of slaves served 12 years as mayor of the South's largest city. His tenure saw the construction of what would become the world's busiest airport, Hartsfield International.

He was a fierce advocate for those who thought they were forgotten. He became their voice. In him, they found a great fighter.

The New York Times wrote of Maynard's tenure as mayor it created ''a political revolution in the heart of the South. Seemingly overnight, it transformed Atlanta into a mecca for talented, aspiring blacks from all across the country.''

The Washington Post described Maynard's impact this way:

> African Americans around the country looked at Jackson's win . . . and saw even greater possibilities. If they did it in Atlanta in the heart of the Confederacy, they could do it at home, too . . .

Vernon Jordan, himself a native of Atlanta, said his most dramatic awareness the South had changed and the city of Atlanta had changed was the day Maynard took the oath of office as mayor of Atlanta. Vernon said it was an unforgettable moment.

As the angels now sing the praises of Maynard Jackson on the other side of that river, I join the chorus of those who yet remain in glorious song to this glorious individual, his life and legacy truly an example for all of us. And he will not be forgotten anytime soon.

HONORING THE STUDENTS OF EUREKA, SOUTH DAKOTA

Mr. DASCHLE. Mr. President, I rise today to recognize an outstanding achievement of the town of Eureka, SD. Eureka has the honor of being the only South Dakota town where three students have won the National Discover Card Tribute Award Scholarship.

The Discover Card Tribute Award Scholarship is awarded each year to 9 outstanding high school juniors in each state and the District of Columbia. These students are selected based on their leadership skills, special talents, personal obstacles, and commitment to community service.

In South Dakota, the state winners for 2003 hail from such cities as Aberdeen, Brookings, Eureka, Milbank, Presho, Salem, Sioux Falls, and Sturgis. Out of these winners, the top three students are selected to compete with students from across the country for 9 national-level scholarships, and it is in this category that the town of Eureka has excelled.

Since the award was first created 12 years ago, only 4 South Dakotans have won at the national level, beginning with Lori Heilman Leidholt of Bowdle, South Dakota, in 1994. The other 3 come from Eureka.

Sarah Anderson won her scholarship in 2000. Sarah is an award-winning photographer and a tireless advocate for diabetes education. Her renowned kitten calendars sell throughout the state and help raise funds for the Juvenile Diabetes Foundation.

As a diabetic herself, she is able to draw from her own experiences as she speaks with adults and children across South Dakota about the disease. In 1999, she successfully lobbied the South Dakota Legislature to enact legislation expanding health insurance coverage for diabetic supplies and equipment.

Loni Schumacher was next in 2002. A member of her local chapter of Family, Career and Community Leaders of America, she was selected to visit Japan in 2001 on a 6-week exchange.

An only child, she has since adopted ''sisters'' from across the globe. Experiencing a new culture broadened her view of the world, and she has brought those ideals back home to Eureka where she and her family have opened their family farm to exchange students from Brazil and Germany.

Loni has also been closely involved in her school's ''Teens Against Tobacco Use'' organization, and teaches elementary school students about the hazards of tobacco use.

Amanda Imberi is Eureka's winner for 2003. I had the honor of meeting this young woman when I visited Eureka several weeks ago. Just last week, here in Washington, I presented her with the 2003 Tradition of Caring Jefferson Award.

At the age of 9, Amanda lost her mother to cancer. She had to grow up faster than any child should.

Even with all of her schoolwork, cooking, and managing the family's finances, she has still found the time to be active with the American Cancer Society, speaking at rallies across the state on the importance of cancer awareness and prevention, as well as producing a variety show style fundraiser at her high school.

Two more Eureka students have won the scholarship at the state level—John Ostrowski in 1997 and Alisha Lutz in 1998. For a town of approximately 1,200 people, that is a remarkable achievement. It is not only an indication of the desire to succeed shared by these students, it is also a testament to the quality of teachers and schools that produced such outstanding young adults.

I don't know what they are putting in the water in Eureka but, whatever it is, I hope they continue. These young

people are an inspiration to their communities and their fellow students. They have proven there is no obstacle you cannot overcome, and that you should always pursue your dreams.

I commend them and the entire town of Eureka for their achievement, and hope to see even more Discover Card Tribute Award winners from South Dakota in the future.

RECOGNIZING COURTNEY STADD

Mr. STEVENS. Mr. President, I would like to a moment of the Senate's time to recognize someone who has served our Nation with great dignity, humility and energy. For more than two decades, Mr. Courtney Stadd has worked tirelessly to secure America's future in technology, aeronautics, and space. His leadership as a team builder, policymaker, entrepreneur, and senor administration official are evidenced around this city, our Nation and in the horizons that surround the Earth.

In my home State of Alaska, Mr. Stadd helped guide the construction of Kenai and the Alaskan Spaceport Authority. As a board member, he played a critical role in enabling America's newest spaceport to serve the well-being of commercial, public sector, and military interests.

As a member of the Reagan and Bush administrations he was an active voice and proponent for creating commercial markets in geospatial imagery, launch services, information technology and other critical sectors that will advance America's economic far into the 21st century.

In his service to this President, Mr. Stadd led the transition team for NASA and ultimately assumed the role of National Aeronautics and Space Administration, NASA, Chief of Staff/White House Liaison. In this role, he served then administrator, Mr. Dan Goldin—working to support missions and nationwide personnel through the September 11th attacks and anthrax threat, which struck NASA Headquarters, just blocks away from this very body. He served Administrator Goldin until the end of his tenure in November 2001 and provided for a smooth and orderly transition for NASA's current administrator, my friend, Mr. Sean O'Keefe.

During his transition into NASA, Administrator O'Keefe found a valued partner and ally to support his vision and charge for fundamental management and financial reform within the agency. He asked Courtney to lead the Freedom to Manage Initiative, which focused on empowering NASA's extraordinary workforce to identify policies and regulations that impeded performance. The administrator also took advantage of Stadd's distinguished commercial background and asked for his assistance in restructuring NASA's accounting systems and management strategies. Both efforts have put NASA on solid ground and will enable the agency that revealed the secrets of the heavens to once again soar without abandon.

His service to this administrator and its workforce know no boundary and for that reason, Mr. O'Keefe called upon Courtney's talents and energies for support during the Columbia accident and its subsequent investigation. His care for the crew, their families, and the entire NASA workforce truly distinguished itself during some very challenging days.

As my words have chronicled, Courtney Stadd has been a faithful and valuable colleague for Administrator O'Keefe and the NASA workforce to depend upon. He has been a model to his peers and colleagues at NASA, the aerospace community and throughout the administration of integrity and poise in service to the American public. We are blessed in a Nation as bountiful as this one to have people such as him who take upon the cloak of public service and perform so admirably.

In the coming days, Mr. Stadd will be departing from his position at NASA to return to private life. As he leaves public service, the Members of this body and administration should pause to recognize him for his distinguished service. He has contributed much in his distinguished career to better America and I am greatful to honor him today.

I wish him well in all of his endeavors.

SUPREME COURT DECISION IN MICHIGAN

Mr. DURBIN. Mr. President, I rise in praise of yesterday's Supreme Court decision in the Michigan case—the most important affirmative action case in a generation. I along with 11 of my colleagues—Senators DASCHLE, KENNEDY, CLINTON, CORZINE, EDWARDS, FEINGOLD, KERRY, LANDRIEU, LAUTENBERG, SCHUMER, and STABENOW—filed an amicus brief in support of the university's affirmative action programs.

I am disappointed that the Court struck down the undergraduate admissions program, but I believe that the opinion upholding the law school program represents a significant victory for affirmative action and for America.

The Court's decision reaffirms the compelling interest in racial and ethnic diversity—universities may continue to include race as one factor among many when selecting its students. Diversity programs promote the integration and full participation of all groups in our society. The core holding of Grutter v. Bollinger, the law school case, and Gratz v. Bollinger, the undergraduate case, boils down to this: universities must look at each applicant individually.

Michigan Law School's program was upheld because the law school performs an individualized consideration of every applicant. Race is considered, but not in a mechanical manner. The University of Michigan's undergraduate program was struck down because the Court said its point system was too rigid and too mechanical. The bottom line is that university affirmative action—when done right—is alive and well in America. Not surprisingly, the law school opinion was 5–4 and, not surprisingly, Justice O'Connor was the swing vote. She has been the crucial swing vote in so many important Supreme Court cases over the past 20 years that she is now routinely referred to as ''the most powerful jurist in America,'' and indeed, as ''the most powerful woman in America.'' Both descriptions may well be true.

I would like to briefly discuss what I think are the three most important aspects of yesterday's decision.

First, the Court set out a clear roadmap for affirmative action. The question is no longer whether race can be used to further diversity, but how it can be used. The majority of universities are already practicing affirmative action the right way. As discussed in today's Washington Post, most universities currently have admissions programs that are similar to Michigan Law School's. And for those that don't, a quick fix would be to go out and hire more admissions officers. Many universities have large endowments, so I am confident they have the ability to hire a few more staff. As a result, they will be able to conduct the flexible, individualized analysis that the Court now demands.

I personally agree with Justice Souter's dissent in the undergraduate case—their point system is a far cry from the quota system that was struck down in Bakke. Underrepresented minorities automatically get 20 points out of a possible 150, but so do athletes, low-income applicants, and those who attended disadvantaged high schools. To me, this type of point system does not seem unconstitutional.

But in any event, universities now have clear guidance. I think Justice Scalia will be proven wrong in his dire prediction that the Michigan decisions will lead to an avalanche of new affirmative action litigation.

Another important aspect of yesterday's decision is that it recognizes the value of diversity not only on campus, but for other critical areas of our society as well. Eliminating affirmative action in universities would have harmful ripple effects for the nation.

For universities, the Court noted that ''classroom discussion is livelier, more spirited, and simply more enlightening and interesting'' when the students have ''the greatest possible variety of backgrounds.''

For society at large, diversity has even more tangible benefits. Citing to an amicus brief filed by a large number of Fortune 500 companies, Justice O'Connor wrote that ''American businesses have made clear that the skills needed in today's increasingly global marketplace can only be developed through exposure to widely diverse people, cultures, ideas, and viewpoints.''

Referencing an amicus brief filed by dozens of retired U.S. military leaders—including Generals Norman Schwarzkopf, John Shalikashvili, Hugh Shelton, Anthony Zinni, and Wesley Clark—the Court wrote that ''high-ranking retired officers and civilian leaders of the United States military assert that, 'based on their decades of experience,' a 'highly qualified, racially diverse officer corps . . . is essential to the military's ability to fulfill its principle mission to provide national security' ''.

In addition, the Court brought the issue of diversity close to home. Noting that law schools represent ''the training ground or a large number of our Nation's leaders,'' the Court observed that individuals with law degrees occupy more than half the seats in the United States Senate (59), a third of the seats in the House of Representatives (161), and roughly half the state governorships.

A third important aspect of yesterday's decision is the rejection of the Bush Administration's position that both Michigan programs were unconstitutional and should be struck down. It gives you an idea of how conservative the Bush Administration is. Even this Supreme Court—in which 7 of 9 members were appointed by Republican Presidents—rejected its arguments.

Contrary to the misleading assertions of President Bush and other opponents of affirmative action, the Court held that Michigan Law School's policy of seeking a ''critical mass'' of minority students did not as a de facto quota.

Between 1993 and 2000, the number of African Americans, Native Americans, and Latinos in each class varied from 13% to 20%. As the Court noted, diminishing stereotypes about ''minority viewpoints'' is ''a crucial part of the Law School's mission, and one that it cannot accomplish with only token numbers of minority students.''

The Court also rejected the Bush Administration's position that you could attain diversity through race-neutral means, such as the ''percentage plans'' in Texas, Florida, and California, which guarantee admission to all student about a certain class-rank threshold in every high school in the state.

The Court rejected this argument for two main reasons: 1, percentage plans don't work for graduate and professional schools, and 2, they are, ironically, even more mechanical and inflexible than the Michigan undergraduate program.

The Court shot down another central argument of the Bush Administration—that affirmative action programs were invalid unless they had a definitive end date. As Justice O'Connor observed: ''It has been 25 years since Justice Powell first approved the use of race to further an interest in student body diversity in the context of public higher education. Since that time, the number of minority applicants with high grades and test scores has indeed increased. We expect that 25 years from now, the use of racial preferences will no longer be necessary to further the interest approved today.''

I hope that Justice O'Connor is right.

The Michigan case is yet another reminder of the fragile balance on the Supreme Court, and how high the stakes will be if a Justice retires.

If there were a switch of a single Justice in yesterday's case, things would be dramatically different today. If there had been a fifth vote to end race-conscious affirmative action in America's universities, we would face a sudden reduction in minority students on our Nation's college campuses, especially at the elite ones.

The dean of Georgetown Law School—my alma mater—speculated yesterday that if the decision had gone the other way, Georgetown's minority enrollment would have been cut in half.

America cannot afford to turn back the clock on opportunity for all of our citzens and—by a 5–4 margin—the Supreme Court agrees.

LOCAL LAW ENFORCEMENT ACT OF 2003

Mr. SMITH. Mr. President, I rise today to speak about the need for hate crimes legislation. On May 1, 2003, Senator KENNEDY and I introduced the Local Law Enforcement Act, a bill that would add new categories to current hate crimes law, sending a signal that violence of any kind is unacceptable in our society.

I would like to describe a terrible crime that occurred on October 8, 2001. In Hyannis, MA, a 31-year-old man attacked two convenience store clerks from Pakistan. The suspect walked into the store, approached the two clerks and asked them if they were from Pakistan. The two men responded affirmatively, which further enraged the suspect. The perpetrator began cursing and accusing the pair for ''almost killing'' his family and attacking the United States. One of the clerks attempted to calm the man down and led him outside. Once outside, the man punched the clerk, sending him to the ground. The attacker proceeded to kick him until the second clerk rushed outside to halt the attack. The man was later arrested by police.

I believe that Government's first duty is to defend its citizens, to defend them against the harms that come out of hate. The Local Law Enforcement Enhancement Act is a symbol that can become substance. I believe that by passing this legislation and changing current law, we can change hearts and minds as well.

VIOLENCE AGAINST WOMEN OFFICE

Mr. BIDEN. Mr. President, I rise to speak today to mark several important developments in our Nation's fight to end domestic violence, sexual assault, and stalking. First, I recently had the honor of addressing domestic violence advocates from across the country who have convened in Washington, DC, to attend the annual meeting of the National Network to End Domestic Violence. These are the women and men on the front lines, transforming the Violence Against Women Act from words on a piece of paper into real solutions for battered women and children.

These advocates witness the terrible toll of family violence. They, in essence, know the statistics by heart. Statistics like 20 percent of all nonfatal violence against females over 12 years of age were committed by intimate partners, according to government statistics released in February 2003. Or the statistics that tell us that in 2000 alone, 1,247 women were killed by an intimate partner. These advocates experience what the studies confirm; that is, in almost half of the households with domestic violence, there are children under the age of 12.

In the face of such daunting numbers, I was pleased to tell these advocates that our fight for an independent and separate Violence Against Women Office is over. I have been assured by Attorney General Ashcroft that his department will comply with the directive for an independent office that was in the law passed by the Congress last session. I want to make clear that my Violence Against Women Office Act and subsequent push to ensure compliance was not a fight about office space or bureaucratic in-fighting. I introduced this legislation because I know that a separate office means that the office's leadership and agenda cannot be marginalized or pushed to a back office. A separate office means that violence against women issues stay at the forefront and that its director appointed by the President and confirmed by the Senate will have an office with the stature and status to use it as the bully pulpit on domestic violence issues that I intended when I authored the Violence Against Women Act.

Nor is the independent office simply a Joe Biden issue. The Violence Against Women Office Act was voted on favorably—with no objections—in the Senate Judiciary Committee. The act passed unanimously in the Senate and passed overwhelmingly in the House. The mandate for freestanding Violence Against Women Office is Congress' law, not a whim.

Despite the law's clear language and intent, the Department of Justice formally announced in February 2003 that it ''interpreted'' the new law to permit the office to remain as a part of the Office of Justice Program, the arm of the Justice Department which handles grant making, rather than implementing significant policy decisions. I vigorously protested this ''interpretation,'' informing the Justice Department that it was inconsistent with both the plain letter of the law, as well as congressional intent. In fact, I personally called Attorney General

Ashcroft on February 13 to discuss this issue and to urge him to reconsider the Department's position.

On March 24, the Attorney General called to inform me that he had personally reviewed this issue and that he was reversing the Department's February decision. More specifically, he pledged to me that the Office would be moved outside of the Office of Justice Programs to become an independent and distinct office, as called for by the law. He also pledged that the Director of the Office would have a direct line of report to him, and not be required to report through the Assistant Attorney General for the Office of Justice Programs, as the Department had previously required. I am grateful that Attorney General Ashcroft took the time to turn his full attention to this matter, to examine the law and legislative history, and to ensure that his Department correctly implemented the act. I commend the Attorney General for doing ''the right thing'' with respect to the office.

The strength and stature of the Violence Against Women Office will be matched by the strength and stature of its director, Diane Stuart. Pursuant to the new law that requires Senate confirmation, Ms. Stuart testified before the Judiciary Committee earlier this month, and the committee will vote on her nomination on Thursday. Ms. Stuart has been acting director of the office for almost 2 years, and during that time has done terrific work. I am particularly impressed with the extraordinary outreach Ms. Stuart has done thus far, meeting with law enforcement, prosecutors, and service providers from Montgomery County, MD, to Portland, OR. She is truly an expert in the areas of domestic violence, sexual assault, and stalking, and I look forward to working with her as we fight to end family violence in our communities.

REACH-BACK TAX

Mr. COCHRAN. Mr. President, I am concerned about an unfair tax on coal companies and other businesses which is sometimes referred to as the ''reach-back tax.'' It was enacted as part of the Coal Act in the 1992 Energy bill. The Coal Act requires companies to pay a tax on the retirement benefits of miners. The tax applies not only to companies active in the coal mining business but also to companies that are no longer in the coal mining business.

There is one company in the State of Washington that has not employed any miners since the 1950s and is still obligated to pay. Another company that is subject to the tax is the Mississippi Lignite Mining Company, which operates a powerplant at Red Hills near Ackerman, MS. It is time for the Congress to repeal this unfair tax.

If we do not act soon, the combined benefit fund, which provides the money for the retirement benefits, will be bankrupt. I understand that the distinguished chairman of the Senate Finance Committee, Mr. GRASSLEY, and the Senator from Oregon, Mr. SMITH, have asked the House Ways and Means Committee to send a bill to the Senate to resolve this issue. I join them in this request and hope the Finance Committee will act with favor on such a bill when it comes over from the House.

NATIONAL MUSEUM OF AFRICAN AMERICAN HISTORY AND CULTURE ACT

Mr. KENNEDY. Mr. President, I strongly support S. 1157, the National Museum of African American History and Culture Act. The story of African Americans is a major part of the story of the United States. From the dark times of slavery, civil war, and reconstruction, to the extraordinary accomplishments of the civil rights movement of the past half century, it is essential for all Americans to know and understand that story in all its aspects, and this new museum in the Nation's Capital will be an especially valuable resource in achieving that goal. It will be a valuable cultural and educational experience for every visitor to Washington and for every student of American history in communities across the country.

Our Nation was founded on a promise of equality and opportunity for all, and for more than two centuries, we have struggled to fulfill that great promise. The struggle goes on today, on critical issues, such as guaranteeing that all our citizens are free from hate crimes and racial profiling, and are free to go to the polls and vote without intimidation or attempts to suppress their votes.

We know that civil rights is still the great unfinished business of America. As Robert Kennedy told the students at the University of Cape Town, at a time when the specter of apartheid hung heavily over South Africa:

> We must recognize the full human equality of all our people—before God, before the law, and in the councils of governments. We must do this, not because it is economically advantageous—although it is; not because the laws of God and man command it—although they do command it; not because people in other lands wish it to. We must do it for the single and fundamental reason that it is the right thing to do.

It is especially appropriate that this new museum dedicated to African-American history and culture will be part of the Smithsonian Institution in Washington. It is long overdue, and this legislation will help advance the cause.

This museum will be renowned as a source of African-American history throughout the United States. In cooperation with other museums, with historically black colleges, and with many other historical, cultural, and educational institutions, it will make this part of the Nation's history as widely available as possible. And millions of visitors who come here from throughout the world will be inspired by what they see and learn.

It is an honor to be a sponsor of this legislation, and I urge my colleagues to support it.

HONORING OUR ARMED FORCES

IN MEMORY OF STAFF SERGEANT AARON WHITE

Mr. INHOFE. Mr. President, I rise today to honor the memory of a remarkable man. SSG Aaron Dean White was an Oklahoman through and through. People say he was a hard worker, dedicated, friendly, and that he loved his family and country. Those who knew him best remembered him as being always willing to help others. He even served alongside his father as a volunteer firefighter for the town of Sasakwa, OK. A former resident of both Sasakwa and Shawnee, OK, he graduated from Shawnee High School in 1994. He entered the U.S. Marine Corps shortly thereafter, gladly serving his Nation for 9 years, and eventually moving up to the position of crew chief on a CH–46 Sea Knight Helicopter.

Staff Sergeant White was passionate about his job—excited to serve—proud to be a marine. After being deployed to Iraq in January of 2003, he was upset because he was not as close to the action as he had hoped. A passionate lover of flying who had earned his pilot's license, he volunteered to be a gunner on a helicopter, just so he would have the opportunity to fly more often.

On Monday, May 19, Staff Sergeant White was one of four individuals on board a helicopter on a resupply mission when the chopper went down into the Shat Ahilala River in Iraq. Tragically he, along with four other marines, did not survive the incident. This courageous man who was living out his dreams lost his life while defending his country.

Staff Sergeant White's remarkable life of helping others was commemorated at his funeral ceremony in Wewoka, OK, at which friends and family filled the chapel. His many loved ones grieved, including his parents, Shawnee, OK, residents Darrell and Karen White; his wife Michele; his daughter Brianna Nicole; and his sister, Sergeant Patricia LaBar, who was serving with the U.S. Army in Germany when her brother passed into the next life. However, I know they are incredibly proud of this man—son, husband, father, and brother—lover of life and soldier of freedom. He is a man who has set a higher standard for all of us to follow. We will never forget him, SSG Aaron Dean White.

IN MEMORY OF PETTY OFFICER BOLLINGER

Mr. INHOFE. Mr. President, no one can truly put into words the magnitude of respect and admiration we feel for those who sacrifice their lives so that we might continue to live in freedom. However, I am honored today to try, since the young man whom I pay tribute to was a proud son of my home State the great State of Oklahoma.

Petty Officer 3rd Class Doyle Wayne Bollinger grew up in the community of Poteau, OK. A member of the Poteau Valley Baptist Church, he was remembered by those who knew him best as one with a generous heart—never thinking of himself, but devoting his time to the service of others.

Upon graduating from Poteau High School, Petty Officer Bollinger heard the call to serve his country. He joined the United States Navy, becoming a member of the Naval Mobile Construction Battalion 133, based in Gulfport, MS. In January of 2003, he and his fellow patriots were sent to Iraq, and possibly into harm's way.

On Friday, June 6, 2003 Petty Officer Bollinger was with his battalion, repairing a bridge across the Tigris River in Iraq. He was tragically killed when unexploded ordnance accidentally detonated nearby. At the age of 21 this man lost his life so that we might stand here today, without fear, and in freedom.

I cannot fully describe to you the pain in the hearts of his loved ones as they sat at his funeral on the grounds of Poteau High School, where they had watched him graduate only a few years earlier. Our thoughts and prayers are with them now. And though we are all grieved at the loss of this man, we shall never cease to be proud of him—Oklahoma's son—Petty Officer 3rd Class Doyle Wayne Bollinger.

IN MEMORY OF PRIVATE FIRST CLASS JEROD R. DENNIS

Mr. INHOFE. Mr. President, I rise today to honor the memory of a man who, at such a young age, displayed the courage and valor of a true American hero. Private First Class Jerod R. Dennis was a proud son of the great State of Oklahoma, growing up in the community of Antlers. Remembered as being energetic, outgoing, and humorous, he graduated in 2002 from Antlers High School, where he was a standout tennis player, twice making it to the State championships.

Even before the attacks on America on 9/11, PVT Dennis knew that he wanted to dedicate himself to service in the United States Army. He enlisted prior to his graduation from high school, and arrived in boot camp merely 3 weeks after receiving his diploma. His parents, Jerry and Jane Dennis of Antlers, realized that their son was proud to be answering the call to serve his country. Despite their worry for his safety, they sent with him their support and love as he was assigned to the 3rd Battalion, 504th Parachute Infantry Regiment based out of Fort Bragg, NC.

As a part of the U.S. effort to stamp out the threat of terrorism, PVT Dennis, now an Army sharpshooter, along with the rest of his regiment, was sent to fight in Afghanistan. On April 25, 2003, PVT Dennis was on patrol in eastern Afghanistan with other soldiers when they drove into an ambush. A firefight with rebel fighters quickly followed. When his sergeant was shot, PVT Dennis made his way to a foxhole and provided cover fire as his comrades took the sergeant to safety. Tragically, PVT Dennis was mortally injured in the process.

At just 19 years of age, PVT Dennis lay dying from his wounds, worrying more about the physical condition of his fellow soldiers than his own health and well being. PVT Dennis passed on to the next life that day, but no one could deny the bravery displayed by this young man from a small town in far southeastern Oklahoma.

Hundreds gathered at the funeral for PVT Dennis, held at the First Baptist Church in Antlers. They will never forget this incredible young man who displayed such great love for his country. As Army Brigadier General Abe Turner stated so eloquently at the funeral ceremony, ''We will remember you. We will honor you, and you will always be a hero.'' He is Oklahoma's hero—Private First Class Jerod R. Dennis.

ADDITIONAL STATEMENTS

TRIBUTE TO LINCOLN COUNTY AND MESCALERO APACHE INDIAN HEROES

● Mr. DOMENICI. Mr. President, I rise today as we move toward the American Independence Day holiday to honor a group of dedicated people in Lincoln County and the Mescalero Apache Tribe of New Mexico who have launched a major project to ensure that their war dead are never forgotten.

These citizens, led by Walter Patrick Limacher of Hondo, are compiling and publishing the ''Lincoln County and Mescalero Apache Tribe Honor List.'' This list includes the names of all those from this mountainous southern New Mexico region who gave their lives defending the United States in World War I, World War II, the Korean war, and Vietnam.

As families and communities rally on July 4th to celebrate the 227th birthday of our Nation, the honor list organizers understand that our celebrations are made possible by the servicemen who came from their very own small communities and ranches to take up arms in the name of liberty and freedom.

The honor list serves to unify this region of New Mexico, equally paying tribute to those who made the ultimate sacrifice. The list reads like the history of New Mexico itself, including warriors of American Indian, Hispanic, Anglo and other descents.

The collection has been a joint effort of a great many, from tribal and county citizens and officials, to the Department of Defense. My distinguished colleague from Arizona, Senator MCCAIN, Secretary of State Colin Powell, General Norman Schwarzkopf, and former New Mexico Governor Gary Johnson have all issued citations to the list. I want to take this opportunity to thank Mr. Limacher for his dedication and tireless work.

I, too, take pride in honoring these servicemen. They are all specially honored in this record.

The Lincoln County and the Mescalero Apache Indian Tribe Honor List will be presented to surviving family members of those who served, and placed in libraries located throughout south central New Mexico so all can remember these great men. The stories of these brave servicemen from Lincoln County and the Mescalero Apache Indian Reservation are forever unfinished because of the circumstance of their deeds, but their sacrifices do not go unnoticed. The honor list will create a unique bond between future generations and the past fallen heroes.

They are all heroes who fought for their country and gave their lives for our freedom, liberty, and independence. Because of their courage we are what we are. To them and their families, and to all our men and women of our armed services past and present, I salute you this Independence holiday.●

AL BRAIMAN: DEPAUL UNIVERSITY CLASS OF 2003

● Depaul University's Class of 2003. Al was the oldest graduate of Depaul's Class of 2003 when he graduated on June 14. Al completed a degree in liberal arts at Depaul's College of New Learning with a grade point average of 3.92 out of a possible 4.0.

Born in Kiev, Russia, in 1920, Al immigrated to the United States at the age of one. His family took up residency in Chicago, where he lived most of his life. After high school, Al turned down an academic scholarship for college to support his family. Al joined the Army and served with distinction in WWII, spending most of his time on Guadalcanal.

After leaving the Army, Al owned and operated Lakeview Grocerland until the mid 1960s when he became an insurance salesman with Equitable Life Insurance Company. He became a certified life underwriter and chartered financial consultant. Al won many awards in the industry, including induction to the Equitable Hall of Fame.

After retiring in 1985, Al decided to earn a college degree, something he promised his mother earlier in his life. Al's interest in politics led him to take many political science and history courses at Depaul University. Some of his favorites included a class on American Presidents and a course on race relations. He also enjoyed learning many new things such as use of the Internet, photography, and art. Al has proven that it is never too late to learn and we could all learn a great deal from his perseverance.

I know my fellow Senators will join me in congratulating Al Braiman, Depaul Class of 2003. His story contains all the elements of a great American life and I am honored to share it with my colleagues in the Senate.●

NASHUA CELEBRATES ITS SESQUICENTENNIAL

● Mr. GREGG. Mr. President, I rise today in honor of Nashua, NH, the Gate City of New Hampshire. As the United States prepares to observe the 227th anniversary of our independence, the citizens of Nashua will be celebrating the city's sesquicentennial. It is therefore timely and appropriate that we recognize this great American community .

With its rich heritage and the continuing role it plays in New Hampshire's economic and cultural vitality, I am proud to be a native of Nashua. We cannot accurately talk about this city without praising its most distinctive asset: the people of Nashua. From its founding as the Township of Dunstable in 1673 to its incorporation as the City of Nashua in 1853 through today, they have shown a unique entrepreneurial flair, a dedication to their neighbors and the courage to often times place their own lives at risk for the well-being of our country. Their involvement in the American Revolution is one of many episodes which vividly illustrate these characteristics. The residents in what was then called Dunstable, upon hearing of the fight at Lexington, rushed to take up arms. According to historical accounts, nearly one-half of the able-bodied men in Dunstable enlisted in the Army by the time of the Battle of Bunker Hill. CAPT William Walker organized a company of 66 of these men for this battle. They were placed at the high point of the British attack. To be stationed here was actually a great honor as it reflected their fighting expertise and commitment to the cause of independence.

Since then, Nashuans have continued to serve and defend their country when our freedoms were at risk: 1,348 men served in the Civil War; 4,160 in World War Two. Nashua's airport is named after Paul Boire, a young navy pilot who died in March, 1943. Women, too, have greatly contributed to these causes, oftentimes on the front lines. Mrs. Adelaide Johnson Stevens was a volunteer nurse during the Civil War and was wounded during the assault on Fort Harrison.

In the early part of the 1800s, the community was quickly becoming a center for commerce and industry. Daniel Abbott was the man perhaps most responsible for this reputation. He, along with partners Joseph Greeley and Moses Tyler, founded the Nashua Manufacturing Company which became one of the world's preeminent manufacturers of cotton, woolen, and iron goods. Throughout the 19th century, Nashua was well known as a center for innovation. For example, the Nashua Iron and Steel Works made the stoppers for the ports in the turrets of the S.S. *Monitor.* The Rollins Engine Company made the famous steam engine which help power the economic expansion not only in New Hampshire but throughout our country. As Nashua grew, so did its reputation as a home for entrepreneurs. Royden Sanders turned Sanders Associates into one of the top defense contractors in our country. In an interesting sidenote, Ralph Baer, who worked as a manager for Sanders in the 1960s, developed the first television video game and is often called the Tom Edison of video games. Sanders is now owned by BAE Systems but continues to be a pioneer in the design, development, and manufacture of electronic systems for both military and commercial use.

What is perhaps the most distinguishing characteristic of the city's people has always been their commitment to helping their neighbors and to constantly improving the quality of life here. Nashua's history is full of stories which illustrate their dedication. On April 20, 1861, the city passed soldiers aid resolution providing one dollar per week for the wife of an enlistee and one dollar per week for each dependent child. Today, Nashua has organizations like Marguerite's Place which has done so much to turn around the lives of women and their children who have been victims of domestic violence. The city's current mayor, Bernie Streeter, has long served the public and is continuing in the honorable tradition started by Nashua's first mayor, Josephus Baldwin. My father, Hugh Gregg, has also served as mayor of Nashua and Governor of New Hampshire. It was in large part through his work that the city's economic vitality was restored after the mills moved and closed in the early 1950s.

All of these people, and their stories, demonstrate how Nashua has maintained its vitality, adapted to changing times, and continues to be a leader in so many areas. It is no wonder that the city has twice been named as the best place to live in the United States. I do not think any other community in the country can make that claim. With that, I am proud to honor and salute them as they celebrate the sesquicentennial of Nashua, NH.●

TRIBUTE TO JUDGE LEE AND HARRY FIRST

● Mr. LIEBERMAN. Mr. President, a great thinker once said that there is no more lovely, friendly, and charming relationship, communion, or company than a good marriage. Judge Lee and Harry First of Riverdale, New York, have certainly demonstrated the truth of those stirring words. For 50 years, they have set an example of commitment, faith, and values. They have been blessed with a strong and happy marriage and a loving family. I am delighted to wish our very good friends, Lee and Harry, a happy 50th wedding anniversary and a joyous celebration.●

MESSAGE FROM THE HOUSE

ENROLLED BILLS SIGNED

At 9:33 a.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the Speaker has signed the following enrolled bills:

S. 342. An act to amend the Child Abuse Prevention and Treatment Act to make improvements to and reauthorize programs under that Act, and for other purposes.

S. 1276. An act to improve the manner in which the Corporation for National and Community Service approves, and records obligations relating to, national service positions.

H.R. 2312. An act to amend the Communications Satellite of 1962 to provide for the orderly dilution of the ownership interest in Inmarsat by former signatories to the Inmarsat Operating Agreement.

H.R. 658. An act to provide for the protection of investors, increase confidence in the capital markets system, and fully implement the Sarbanes-Oxley Act of 2002 by streamlining the hiring process for certain employment positions in the Securities and Exchange Commission.

The enrolled bills were signed subsequently by the President pro tempore (Mr. STEVENS).

At 2:15 p.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the House has passed the following bill, in which it requests the concurrence of the Senate:

H.R. 2465. An act to extend for six months the period for which chapter 12 of title 11 of the United States Code is reenacted.

The message further announced that the House has agreed to the following concurrent resolution, in which it requests the concurrence of the Senate:

H. Con. Res. 209. Concurrent resolution commending the signing of the United States-Adriatic Charter, a charter of partnership among the United States, Albania, Croatia, and Macedonia.

The message also announced that pursuant to 22 U.S.C. 3003 note, and the order of the House of January 8, 2003, the Speaker appoints the following Members of the House of Representatives to the Commission on Security and Cooperation in Europe: Mr. SMITH of New Jersey, acting Chairman, Mr. WOLF, of Virginia, Mr. PITTS, of Pennsylvania, Mr. ADERHOLT, of Alabama, Mrs. NORTHUP, of Kentucky, Mr. CARDIN, of Maryland, Ms. SLAUGHTER, of New York, and Mr. HASTINGS, of Florida.

MEASURE REFERRED

The following concurrent resolution was read, and referred as indicated:

H. Con. Res. 209. Concurrent resolution commending the signing of the United States-Adriatic Charter, a charter of partnership among the United States, Albania, Croatia, and Macedonia; to the Committee on Foreign Relations.

MEASURE READ THE FIRST TIME

The following bill was read the first time:

S. 1323. A bill to extend the period for which chapter 12 of title 11, United States Code, is reenacted by 6 months.

ENROLLED BILLS PRESENTED

The Secretary of the Senate reported that on today, June 24, 2003, she had presented to the President of the United States the following enrolled bills:

S. 342. An act to amend the Child Abuse Prevention and Treatment Act to make improvements to and reauthorize programs under that Act, and for other purposes.

S. 1276. An act to improve the manner in which the Corporation for National and Community Service approves, and records obligations relating to, national service positions.

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, and were referred as indicated:

EC–2842. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Allocation of Fiscal Year 2003 Operator Training Grants'' received on June 18, 2003; to the Committee on Environment and Public Works.

EC–2843. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Approval and Promulgation of Implementation Plans; Revisions to the Kentucky Nitrogen Oxides Budget and Allowance Trading Program'' (FRL7516–1) received on June 18, 2003; to the Committee on Environment and Public Works.

EC–2844. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Approval and Promulgation of Implementation Plans: State of Missouri'' (FRL7513–9) received on June 18, 2003; to the Committee on Environment and Public Works.

EC–2845. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Approval and Promulgation of Implementation Plans; Wisconsin; Revised Motor Vehicle Emissions Inventories and Motor Vehicle Emissions Budgets using MOBILE6'' (FRL7515–5) received on June 18, 2003; to the Committee on Environment and Public Works.

EC–2846. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Change of Address for Submission of Certain Reports; Technical Amendment'' (FRL7513–8) received on June 18, 2003; to the Committee on Environment and Public Works.

EC–2847. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Correction of Designation of Areas for Air Quality Planning Purposes; California—PM–10 Nonattainment Area'' (FRL7516–9) received on June 18, 2003; to the Committee on Environment and Public Works.

EC–2848. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Criteria for Classification of Solid Waste Disposal Facilities and Practices and Criteria for Municipal Solid Waste Landfills: Disposal of Residential Lead-Based Paint Waste'' (FRL7514–7) received on June 18, 2003; to the Committee on Environment and Public Works.

EC–2849. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''National Pollutant Discharge Elimination System—Amendment of Final Regulations Addressing Cooling Water Intake Structures for New Facilities; Final Rule'' (FRL7514–9) received on June 18, 2003 ; to the Committee on Environment and Public Works.

EC–2850. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''OMB Approvals Under the Paperwork Reduction Act; Technical Amendment'' (FRL7314–5) received on June 18, 2003; to the Committee on Environment and Public Works.

EC–2851. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Polychlorinated Biphenyls; Use of Porous Surfaces; Amendment in Response to Court Decision'' (FRL7314–2) received on June 18, 2003 ; to the Committee on Environment and Public Works.

EC–2852. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Supplemental Allocation of Fiscal Year 2003 Operator Training Grants for Wastewater Security'' received on June 18, 2003; to the Committee on Environment and Public Works.

EC–2853. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Virginia: Final Authorization of State Hazardous Waste Management Program Revision'' (FRL7516–4) received on June 18, 2003; to the Committee on Environment and Public Works.

EC–2854. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, a report entitled ''Guidance on the Use of Environmental Management Systems in Enforcement Settlements as Injunctive Relief and Supplemental Environmental Projects''; to the Committee on Environment and Public Works.

EC–2855. A communication from the Acting Chair, Federal Subsistence Board, Fish and Wildlife Service, Department of the Interior, transmitting, pursuant to law, the report of a rule entitled ''Subsistence Management Regulations for Public Lands in Alaska, Subpart C and D—2003–2004 Subsistence Taking of Wildlife Regulations'' (RIN1018–AI62) received on June 18, 2003; to the Committee on Environment and Public Works.

EC–2856. A communication from the Chairman of the Nuclear Regulatory Commission, transmitting, pursuant to law, the March 2003 report on the status of its licensing and regulatory duties; to the Committee on Environment and Public Works.

EC–2857. A communication from the Associate Administrator, Office of Veterans' Business Development, Small Business Administration, transmitting, pursuant to law, a report describing the activities the Advisory Committee on Veterans Business Affairs; to the Committee on Veterans' Affairs.

EC–2858. A communication from the Director, Regulations Management, Police and Security Service, Department of Veterans' Affairs, transmitting, pursuant to law, the report of a rule entitled ''Privacy Act of 1974; Implementation—Exemption of Police and Security Records'' (RIN2900–AL33) received on June 13, 2003; to the Committee on Veterans' Affairs.

EC–2859. A communication from the Director, Regulations Management, Veterans' Benefits Administration, Department of Veterans' Affairs, transmitting, pursuant to law, the report of a rule entitled ''Increase in Rates Payable Under the Montgomery GI Bill—Active Duty and Survivors' and Developments' Educational Assistance Program'' (RIN2900–AL17) received on June 18, 2003; to the Committee on Veterans' Affairs.

EC–2860. A communication from the Director, Regulations Management, Veterans' Benefits Administration, Department of Veterans' Affairs, transmitting, pursuant to law, the report of a rule entitled ''Veterans Education: Additional Opportunity to Participate in the Montgomery GI Bill and Other Miscellaneous Issues'' (RIN2900–AK81) received on June 18, 2003; to the Committee on Veterans' Affairs.

EC–2861. A communication from the Director, Regulations Management, Veterans' Benefits Administration, Department of Veterans' Affairs, transmitting, pursuant to law, the report of a rule entitled ''Compensation and Pension Provisions of the Veterans Education and Benefits'' (RIN2900-AL29) received on June 18, 2003; to the Committee on Veterans' Affairs.

EC–2862. A communication from the Assistant Attorney General, Department of Justice, transmitting, a draft of proposed legislation relating to sexual abuse and contraband offenses relating to Federal prisoners; to the Committee on the Judiciary.

EC–2863. A communication from the Secretary of Health and Human Services, transmitting, pursuant to law, the Annual Report on the Refugee Resettlement Program for the period from October 1 , 2000 through September 30, 2001; to the Committee on the Judiciary.

EC–2864. A communication from the Under Secretary and Director, United States Patent and Trademark Office, transmitting, pursuant to law, the report of a rule entitled ''Elimination of Continued Prosecution Application Practice as to Utility and Plant Patent Applications'' (RIN0651–AB37) received on June 19, 2003; to the Committee on the Judiciary.

EC–2865. A communication from the Assistant Legal Adviser for Treaty Affairs, Department of State, transmitting, pursuant to law, the report of the texts and background statements of international agreements other than treaties; to the Committee on Foreign Relations.

EC–2866. A communication from the Assistant Secretary of Legislative Affairs, Department of State, transmitting, pursuant to law, Presidential Determination number 2002–26, relative to Suspension of Limitations under the Jerusalem Embassy Act

EC–2867. A communication from the Assistant Secretary of Legislative Affairs, Department of State, transmitting, pursuant to law, a report concerning the program recommendation of the Amman, Jordan, Accountability Review Board relative to Laurence Foley; to the Committee on Foreign Relations.

EC–2868. A communication from the President of the United States, transmitting, pursuant to law, a report concerning the Authorization for Use of Military Force Against Iraq Resolution of 2002; to the Committee on Foreign Relations.

EC–2869. A communication from the Chairman and President of the Export-Import Bank of the United States, transmitting, pursuant to law, a report relative to a transaction involving U.S. exports to Vietnam; to

the Committee on Banking, Housing, and Urban Affairs.

EC–2870. A communication from the Chairman and President of the Export-Import Bank of the United States, transmitting, pursuant to law, a report relative to a transaction involving U.S. exports to Australia; to the Committee on Banking, Housing, and Urban Affairs.

EC–2871. A communication from the Assistant Secretary for Export Administration, Bureau of Industry and Security, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Imposition and Expansion of Controls on Designated Terrorists'' (RIN0694–AC60) received on June 19, 2003; to the Committee on Banking, Housing, and Urban Affairs.

EC–2872. A communication from the Acting General Counsel, Federal Emergency Management Agency, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Final Flood Elevation Determinations'' (44 CFR Part 67) received on June 19, 2003; to the Committee on Banking, Housing, and Urban Affairs.

EC–2873. A communication from the Acting General Counsel, Federal Emergency Management Agency, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Changes in Flood Elevation Determinations'' (44 CFR Part 65) received on June 19, 2003; to the Committee on Banking, Housing, and Urban Affairs.

EC–2874. A communication from the Assistant General Counsel for Regulations, Office of the Secretary, Department of Housing and Urban Development, transmitting, pursuant to law, the report of a rule entitled ''Open Competition and Government Neutrality Towards Government Contractors' Labor Relations on Federal and Federally Funded Construction Projects'' (RIN2501–AC98) received on June 19, 2003; to the Committee on Banking, Housing, and Urban Affairs.

EC–2875. A communication from the Assistant Secretary, Investment Management, Securities and Exchange Commission, transmitting, pursuant to law, the report of a rule entitled ''Certain Research and Development Companies'' (RIN3235–AI57) received on June 17, 2003; to the Committee on Banking, Housing, and Urban Affairs.

EC–2876. A communication from the Secretary of Education, transmitting, pursuant to law, the report of the Office of the Inspector General for the period October 1, 2002 through March 31 , 2003; to the Committee on Governmental Affairs.

EC–2877. A communication from the Secretary of the Treasury, transmitting, pursuant to law, the report of the Office of the Inspector General and the Treasury Inspector General for Tax Administration Report for the period from October 1, 2002 through March 31, 2003; to the Committee on Governmental Affairs.

EC–2878. A communication from the Comptroller General of the United States, transmitting, pursuant to law, the report of the list of General Accounting Office reports for April 2003; to the Committee on Governmental Affairs.

EC–2879. A communication from the Secretary of the Interior, transmitting, pursuant to law, the report of the Office of the Inspector General for the period from October 1, 2002 through March 31, 2003; to the Committee on Governmental Affairs.

EC–2880. A communication from the Secretary of Agriculture, transmitting, pursuant to law, the report of the Office of the Inspector General for the period from October 1, 2002 through March 31, 2003; to the Committee on Governmental Affairs.

EC–2881. A communication from the Chairman, National Credit Union Administration, transmitting, pursuant to law, the report of the Office of the Inspector General for the period from October 1, 2002 through March 31, 2003; to the Committee on Governmental Affairs.

EC–2882. A communication from the Chairman, Consumer Product Safety Commission, transmitting, pursuant to law, the report of the Office of the Inspector General for the period from October 1, 2002 through March 31, 2003; to the Committee on Governmental Affairs.

EC–2883. A communication from the Chairman, United States Parole Commission, Department of Justice, transmitting, pursuant to law, the Commission's report under the Government in the Sunshine Act for the years 2000 through 2002; to the Committee on Governmental Affairs.

EC–2884. A communication from the Federal Co-Chair, Appalachian Regional Commission, transmitting, pursuant to law, the report of the Office of the Inspector General for the period from October 1, 2002 through March 31, 2003; to the Committee on Governmental Affairs.

EC–2885. A communication from the Chairman, National Science Board, transmitting, pursuant to law, the report of the Office of the Inspector General for the period from October 1, 2002 through March 31, 2003; to the Committee on Governmental Affairs.

EC–2886. A communication from the Chairman of the Board of Governors, United States Postal Service, transmitting, pursuant to law, the report of the Office of the Inspector General for the period from October 1, 2002 through March 31, 2003; to the Committee on Governmental Affairs.

EC–2887. A communication from the Chairman, United States Government National Labor Relations Board, transmitting, pursuant to law, the report of the Office of the Inspector General for the period from October 1, 2002 through March 31, 2003; to the Committee on Governmental Affairs.

EC–2888. A communication from the Assistant Administrator for Procurement, National Aeronautics and Space Administration, transmitting, pursuant to law, the report of a rule entitled ''NASA Grant and Cooperative Agreement Handbook—Incremental Funding'' (RIN2700–AC53) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2889. A communication from the Chief of Regulations and Administrative Law, United States Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Drawbridge Regulations: (4)'' (RIN1625–AA09) received on June 13, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2890. A communication from the Chief of Regulations and Administrative Law, United States Coast Guard, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Licensing and Manning for Officers of Towing Vessels'' (RIN1625–AA41) received on June 13, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2891. A communication from the Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Closure; Prohibiting Directed Fishing for Species that Comprise Deep-Water Species Fishery by Vessels Using Trawl Gear in the Gulf of Alaska'' received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2892. A communication from the Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Closure; Prohibiting Directed Fishing for Yellowfin Sole by Vessels Using Trawl Gear in Baycatch Limitation Zone 1 of the Bering Sea and Aleutian Islands Management Area'' received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2893. A communication from the Deputy Assistant Administrator for Regulatory Programs, National Marine Fisheries Service, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Antarctic Marine Living Resources; CCAMLR Ecosystem Monitoring Permits; Vessel Monitoring System; Catch Documentation Scheme; Fishing Season; Registered Agent; and Disposition of Seized AMLR'' (RIN0648–AP74) received on June 19, 2004; to the Committee on Commerce, Science, and Transportation.

EC–2894. A communication from the Assistant Administrator for Fisheries, National Marine Fisheries Service, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Atlantic Highly Migratory Species; Commercial Shark Management Measures; Emergency Rule; Extension of Expiration Date ; Request for Comments; Fishing Season Notification'' (RIN0648–AQ39) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2895. A communication from the Deputy Assistant Administrator for Regulatory Programs, National Marine Fisheries Service, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Framework Adjustment 2 to the Monkfish Fishery Management Plan'' (RIN0648–AQ29) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2896. A communication from the Deputy Assistant Administrator for Regulatory Programs, National Marine Fisheries Service, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Final Rule: Regulations Governing the Taking and Importing of Marine Mammals; Eastern North Pacific Southern Resident Killer Whales'' (RIN0648–AQ00) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2897. A communication from the Secretary, Federal Trade Commission, transmitting, pursuant to law, the report of a rule entitled ''Rule Concerning Disclosures Re. Energy Consumption and Water Use of Certain home Appliances and Other Products Required Under the Energy Policy and Conservation Act—Final Rule and Conditional Exemption for Clothes Washer Labels'' (RIN3084–AA74) received on June 21, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2898. A communication from the Attorney Advisor, Department of Transportation, transmitting, pursuant to law, the report of a nomination for the position of Assistant Secretary for Governmental Affairs; to the Committee on Commerce, Science, and Transportation.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. GRASSLEY, from the Committee on Finance, without amendment:

S. 312. A bill to amend title XXI of the Social Security Act to extend the availability of allotments for fiscal years 1998 through 2001 under the State Children's Health Insurance Program (Rept. No. 108–78).

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first

and second times by unanimous consent, and referred as indicated:

By Mr. BROWNBACK (for himself, Mr. DORGAN, Mr. GRASSLEY, Mr. BAUCUS, Mr. DASCHLE, Mr. ROBERTS, Mr. BURNS, Mr. BOND, Mr. ALLARD, Mr. HAGEL, Mr. DEWINE, Mr. CRAIG, Mr. LEVIN, Mr. LEAHY, Mr. CONRAD, Mr. HARKIN, and Mr. JEFFORDS):

S. 1316. A bill to treat payments under the Conservation Reserve Program as rentals from real estate; to the Committee on Finance.

By Mr. SMITH (for himself, Mr. BIDEN, and Mr. DURBIN):

S. 1317. A bill to amend the American Servicemember's Protection Act of 2002 to provide clarification with respect to the eligibility of certain countries for United States military assistance; to the Committee on Armed Services.

By Ms. SNOWE:

S. 1318. A bill to deauthorize the project for navigation, Tenants Harbor, Maine; to the Committee on Environment and Public Works.

By Ms. SNOWE:

S. 1319. A bill to deauthorize the project for navigation, Northeast Harbor, Maine; to the Committee on Environment and Public Works.

By Ms. SNOWE:

S. 1320. A bill to modify the project for navigation, Union River, Maine; to the Committee on Environment and Public Works.

By Mrs. CLINTON (for herself, Mrs. MURRAY, and Mr. BINGAMAN):

S. 1321. A bill to authorize resources to foster a safe learning environment that supports academic achievement for all students by improving the quality of interim alternative educational settings, providing more behavioral supports in schools, and supporting whole school interventions; to the Committee on Health, Education, Labor, and Pensions.

By Mr. SCHUMER:

S. 1322. A bill to require States to make certain information regarding sexually violent predators accessible on the Internet; to the Committee on the Judiciary.

By Mr. GRASSLEY (for himself, Mr. LEAHY, and Mr. SESSIONS):

S. 1323. A bill to extend the period for which chapter 12 of title 11, United States Code, is reenacted by 6 months; read the first time.

By Mr. GRASSLEY (for himself and Mr. BAUCUS):

S. 1324. A bill to amend the Trade Act of 1974 to establish procedures for identifying countries that deny market access for agricultural products of the United States, and for other purposes; to the Committee on Finance.

By Mr. BURNS (for himself, Mr. GRAHAM of South Carolina, Mr. HAGEL, and Mr. FITZGERALD):

S. 1325. A bill to amend the National Highway System Designation Act of 1995 to modify the applicability of requirements concerning hours of service to operators of commercial motor vehicles transporting agricultural commodities and farm supplies; to the Committee on Commerce, Science, and Transportation.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. SCHUMER (for himself and Mrs. CLINTON):

S. Res. 181. A resolution congratulating all New Yorkers on the occasion of their first Kentucky Derby victory and the subsequent Preakness Stakes victory with New York-bred gelding, Funny Cide; to the Committee on the Judiciary.

By Ms. STABENOW:

S. Res. 182. A resolution congratulating the American Dental Association for establishing the ''Give Kids a Smile'' program, emphasizing the need to improve access to dental care for children , and thanking dentists for volunteering their time to help provide needed dental care; to the Committee on Health, Education, Labor, and Pensions.

ADDITIONAL COSPONSORS

S. 202

At the request of Mr. DEWINE, the names of the Senator from New York (Mr. SCHUMER) and the Senator from New York (Mrs. CLINTON) were added as cosponsors of S. 202, a bill to amend the Internal Revenue Code of 1986 to allow as a deduction in determining adjusted gross income that deduction for expenses in connection with services as a member of a reserve component of the Armed Forces of the United States, to allow employers a credit against income tax with respect to employees who participate in the military reserve components, and to allow a comparable credit for participating reserve component self-employed individuals, and for other purposes.

S. 215

At the request of Mrs. FEINSTEIN, the name of the Senator from Maine (Ms. SNOWE) was added as a cosponsor of S . 215, a bill to authorize funding assistance for the States for the discharge of homeland security activities by the National Guard.

S. 224

At the request of Mr. DASCHLE, the name of the Senator from Vermont (Mr. JEFFORDS) was added as a cosponsor of S. 224, a bill to amend the Fair Labor Standards Act of 1938 to provide for an increase in the Federal minimum wage.

S. 451

At the request of Ms. SNOWE, the name of the Senator from New York (Mrs. CLINTON) was added as a cosponsor of S. 451, a bill to amend title 10, United States Code, to increase the minimum Survivor Benefit Plan basic annuity for surviving spouses age 62 and older, to provide for a one-year open season under that plan, and for other purposes.

S. 518

At the request of Ms. COLLINS, the names of the Senator from Minnesota (Mr. COLEMAN), the Senator from Wisconsin (Mr . FEINGOLD) and the Senator from California (Mrs. BOXER) were added as cosponsors of S. 518, a bill to increase the supply of pancreatic islet cells for research, to provide better coordination of Federal efforts and information on islet cell transplantation, and to collect the data necessary to move islet cell transplantation from an experimental procedure to a standard therapy.

S. 623

At the request of Mr. WARNER, the name of the Senator from Kansas (Mr. ROBERTS) was added as a cosponsor of S. 623 , a bill to amend the Internal Revenue Code of 1986 to allow Federal civilian and military retirees to pay health insurance premiums on a pretax basis and to allow a deduction for TRICARE supplemental premiums.

S. 735

At the request of Mr. BOND, the name of the Senator from Minnesota (Mr. DAYTON) was added as a cosponsor of S. 735, a bill to amend the Internal Revenue Code of 1986 to clarify the exemption from tax for small property and casualty insurance companies.

S. 780

At the request of Mr. LOTT, the name of the Senator from North Dakota (Mr. DORGAN) was added as a cosponsor of S. 780, a bill to award a congressional gold medal to Chief Phillip Martin of the Mississippi Band of Choctaw Indians.

S. 852

At the request of Mr. DEWINE, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of S . 852, a bill to amend title 10, United States Code, to provide limited TRICARE program eligibility for members of the Ready Reserve of the Armed Forces, to provide financial support for continuation of health insurance for mobilized members of reserve components of the Armed Forces, and for other purposes.

S. 863

At the request of Mr. EDWARDS, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of S. 863, a bill to amend the Higher Education Act of 1965 to allow soldiers to serve their country without being disadvantaged financially by Federal student aid programs.

S. 875

At the request of Mr. KERRY, the name of the Senator from Maryland (Ms. MIKULSKI) was added as a cosponsor of S. 875, a bill to amend the Internal Revenue Code of 1986 to allow an income tax credit for the provision of homeownership and community development, and for other purposes.

S. 877

At the request of Mr. BURNS, the name of the Senator from North Carolina (Mr. EDWARDS) was added as a cosponsor of S. 877, a bill to regulate interstate commerce by imposing limitations and penalties on the transmission of unsolicited commercial electronic mail via the Internet.

S. 939

At the request of Mr. HAGEL, the name of the Senator from Montana (Mr. BAUCUS) was added as a cosponsor of S. 939 , a bill to amend part B of the Individuals with Disabilities Education Act to provide full Federal funding of such part, to provide an exception to the local maintenance of effort requirements, and for other purposes.

S. 955

At the request of Mr. ALLEN, the name of the Senator from Oklahoma (Mr. INHOFE) was added as a cosponsor

of S. 955, a bill to provide liability protection to nonprofit volunteer pilot organizations flying for public benefit and to the pilots and staff of such organizations.

S. 973

At the request of Mr. NICKLES, the names of the Senator from Pennsylvania (Mr. SPECTER) and the Senator from Arizona (Mr. KYL) were added as cosponsors of S. 973, a bill to amend the Internal Revenue Code of 1986 to provide a shorter recovery period for the depreciation of certain restaurant buildings.

S. 976

At the request of Mr. WARNER, the names of the Senator from North Carolina (Mrs. DOLE) and the Senator from Texas (Mrs. HUTCHISON) were added as cosponsors of S. 976, a bill to provide for the issuance of a coin to commemorate the 400th anniversary of the Jamestown settlement.

S. 982

At the request of Mrs. BOXER, the name of the Senator from Hawaii (Mr. AKAKA) was added as a cosponsor of S. 982, a bill to halt Syrian support for terrorism, end its occupation of Lebanon, stop its development of weapons of mass destruction, cease its illegal importation of Iraqi oil, and hold Syria accountable for its role in the Middle East, and for other purposes.

S. 1046

At the request of Mr. STEVENS, the name of the Senator from New Jersey (Mr. LAUTENBERG) was added as a cosponsor of S. 1046, a bill to amend the Communications Act of 1934 to preserve localism, to foster and promote the diversity of television programming, to foster and promote competition, and to prevent excessive concentration of ownership of the nation's television broadcast stations.

S. 1082

At the request of Mr. BROWNBACK, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of S. 1082, a bill to provide support for democracy in Iran.

S. 1092

At the request of Mr. CAMPBELL, the name of the Senator from Wisconsin (Mr. FEINGOLD) was added as a cosponsor of S. 1092, a bill to authorize the establishment of a national database for purposes of identifying, locating, and cataloging the many memorials and permanent tributes to America's veterans.

S. 1110

At the request of Mr. BINGAMAN, the name of the Senator from Michigan (Ms. STABENOW) was added as a cosponsor of S. 1110, a bill to amend the Trade Act of 1974 to provide trade adjustment assistance for communities, and for other purposes.

S. 1129

At the request of Mrs. FEINSTEIN, the name of the Senator from North Carolina (Mr. EDWARDS) was added as a cosponsor of S. 1129, a bill to provide for the protection of unaccompanied alien children, and for other purposes.

S. 1153

At the request of Mr. SPECTER, the name of the Senator from Maine (Ms. SNOWE) was added as a cosponsor of S. 1153, a bill to amend title 38, United States Code, to permit medicare-eligible veterans to receive an out-patient medication benefit, to provide that certain veterans who receive such benefit are not otherwise eligible for medical care and services from the Department of Veterans Affairs, and for other purposes.

S. 1218

At the request of Mr. HOLLINGS, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of S. 1218, a bill to provide for Presidential support and coordination of interagency ocean science programs and development and coordination of a comprehensive and integrated United States research and monitoring program.

S. 1236

At the request of Mr. CAMPBELL, the name of the Senator from Nevada (Mr. REID) was added as a cosponsor of S. 1236, a bill to direct the Secretary of the Interior to establish a program to control or eradicate tamarisk in the western States, and for other purposes.

S. 1248

At the request of Mr. GREGG, the names of the Senator from New York (Mrs. CLINTON), the Senator from Connecticut (Mr. DODD), the Senator from Rhode Island (Mr. REED) and the Senator from Washington (Mrs. MURRAY) were added as cosponsors of S. 1248, a bill to reauthorize the Individuals with Disabilities Education Act, and for other purposes.

S. 1289

At the request of Mr. GRAHAM of Florida, the names of the Senator from Georgia (Mr. MILLER) and the Senator from South Dakota (Mr. JOHNSON) were added as cosponsors of S. 1289, a bill to name the Department of Veterans Affairs Medical Center in Minneapolis, Minnesota, after Paul Wellstone.

S. 1290

At the request of Mr. HOLLINGS, the name of the Senator from South Carolina (Mr. GRAHAM) was added as a cosponsor of S. 1290, a bill to amend the Internal Revenue Code of 1986 to allow an additional advance refunding of tax-exempt bonds issued for the purchase or maintenance of electric generation, transmission, or distribution assets.

S. 1293

At the request of Mr. LEAHY, the name of the Senator from Oregon (Mr. WYDEN) was added as a cosponsor of S. 1293, a bill to criminalize the sending of predatory and abusive e-mail.

S. 1293

At the request of Mr. HATCH, the names of the Senator from Montana (Mr. BURNS) and the Senator from Arkansas (Mr. PRYOR) were added as cosponsors of S. 1293, supra.

S. 1294

At the request of Mrs. MURRAY, the names of the Senator from Hawaii (Mr. INOUYE) and the Senator from Minnesota (Mr. DAYTON) were added as cosponsors of S. 1294, a bill to authorize grants for community telecommunications infrastructure planning and market development, and for other purposes.

S. 1303

At the request of Mr. BROWNBACK, the name of the Senator from South Carolina (Mr. HOLLINGS) was added as a cosponsor of S. 1303, a bill to amend title XVIII of the Social Security Act and otherwise revise the Medicare Program to reform the method of paying for covered drugs, drug administration servvices, and chemotherapy support servvices.

S. CON. RES. 40

At the request of Mrs. CLINTON, the names of the Senator from Vermont (Mr. JEFFORDS) and the Senator from Kansas (Mr. BROWNBACK) were added as cosponsors of S. Con. Res. 40, a concurrent resolution designating August 7, 2003, as ''National Purple Heart Recognition Day''.

S. RES. 151

At the request of Mr. GRASSLEY, the name of the Senator from Georgia (Mr. MILLER) was added as a cosponsor of S. Res. 151, a resolution eliminating secret Senate holds.

S. RES. 164

At the request of Mr. ENSIGN, the names of the Senator from Oregon (Mr. WYDEN) and the Senator from New York (Mr. SCHUMER) were added as cosponsors of S. Res. 164, a resolution reaffirming support of the Convention on the Prevention and Punishment of the Crime of Genocide and anticipating the commemoration of the 15th anniversary of the enactment of the Genocide Convention Implementation Act of 1987 (the Proxmire Act) on November 4, 2003.

S. RES. 169

At the request of Mrs. CLINTON, the names of the Senator from Georgia (Mr. MILLER) and the Senator from California (Mrs. BOXER) were added as cosponsors of S. Res. 169, a resolution expressing the sense of the Senate that the United States Postal Service should issue a postage stamp commemorating Anne Frank.

AMENDMENT NO. 956

At the request of Mr. GRAHAM of Florida, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of amendment No. 956 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

AMENDMENT NO. 969

At the request of Mr. DODD, the name of the Senator from Connecticut (Mr. LIEBERMAN) was added as a cosponsor of amendment No. 969 proposed to S. 1,

a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

AMENDMENT NO. 974

At the request of Mr. LEAHY, the name of the Senator from New York (Mr. SCHUMER) was added as a cosponsor of amendment No. 974 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

AMENDMENT NO. 976

At the request of Mr. SARBANES, his name was added as a cosponsor of amendment No. 976 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

AMENDMENT NO. 982

At the request of Mr. LAUTENBERG, the names of the Senator from Rhode Island (Mr. REED), the Senator from New York (Mrs. CLINTON), the Senator from New Jersey (Mr. CORZINE) and the Senator from Nevada (Mr. REID) were added as cosponsors of amendment No. 982 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

AMENDMENT NO. 982

At the request of Ms. MIKULSKI, her name was added as a cosponsor of amendment No. 982 proposed to S. 1, supra.

AMENDMENT NO. 998

At the request of Mr. DODD, the name of the Senator from Massachusetts (Mr. KENNEDY) was added as a cosponsor of amendment No. 998 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

AMENDMENT NO. 998

At the request of Ms. MIKULSKI, her name was added as a cosponsor of amendment No. 998 proposed to S. 1, supra.

AMENDMENT NO. 1000

At the request of Mrs. CLINTON, the names of the Senator from South Dakota (Mr. JOHNSON) and the Senator from New Mexico (Mr. BINGAMAN) were added as cosponsors of amendment No. 1000 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. BROWNBACK (for himself, Mr. DORGAN, Mr. GRASSLEY, Mr. BAUCUS, Mr. DASCHLE, Mr. ROBERTS, Mr. BURNS, Mr. BOND, Mr. ALLARD, Mr. HAGEL, Mr. DEWINE, Mr. CRAIG, Mr. LEVIN, Mr. LEAHY, Mr. CONRAD, Mr. HARKIN, and Mr. JEFFORDS):

S. 1316. A bill to treat payments under the Conservation Reserve Program as rentals from real estate; to the Committee on Finance.

Mr. BROWNBACK. Mr. President, I ask unanimous consent that the ''Conservation Reserve Program Tax Fairness Act of 2003'' be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1316

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Conservation Reserve Program Tax Fairness Act of 2003''.

SEC. 2. TREATMENT OF CONSERVATION RESERVE PROGRAM PAYMENTS AS RENTALS FROM REAL ESTATE.

(a) INTERNAL REVENUE CODE.—Section 1402(a)(1) of the Internal Revenue Code of 1986 (defining net earnings from self-employment) is amended by inserting ''and including payments under section 1233(2) of the Food Security Act of 1985 (16 U.S.C. 3833(2))'' after ''crop shares''.

(b) SOCIAL SECURITY ACT.—Section 211(a)(1) of the Social Security Act is amended by inserting ''and including payments under section 1233(2) of the Food Security Act of 1985 (16 U.S.C. 3833(2))'' after ''crop shares''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to payments made before, on, or after the date of the enactment of this Act.

Mr. DORGAN. Mr. President, I'm pleased to join Senator BROWNBACK and a number of our colleagues today in reintroducing the Conservation Reserve Program Tax Fairness Act. This legislation is virtually identical to the bill we introduced in the 107th Congress, which garnered nearly twenty Senate cosponsors. It clarifies that Conservation Reserve Program, CRP, payments received by farmers are treated for Federal tax purposes as rental payments from real estate, not self-employment income subject to self-employment taxes.

Despite past strong bipartisan support for this legislation, the Congress did not make this long overdue tax law clarification in the major tax reduction bill that was recently signed into law. This is regrettable and I hope that the Congress will move expeditiously to reverse the IRS's wrong-headed position on this matter.

Let me take a moment to describe this problem. For many years, the IRS has been taking the erroneous position that CRP payments received by farmers are income from self-employment and therefore are subject to self-employment taxes. This position imposes a significant financial hardship on family farmers farmers who have voluntarily agreed to take environmentally-sensitive lands out of farm production and place them in the Conservation Reserve Program in return for an annual rental payment from the Commodity Credit Corporation of the U.S. Department of Agriculture.

In our judgment, the IRS's tax treatment of CRP payments is not what Congress intended, nor is it supportable in law. The U.S. Tax Court shares our view that the IRS position is improper. In fact, the U.S. Tax Court ruled in 1998 that CRP payments are properly treated by farmers as rental payments and, thus, not subject to self-employment taxes. Unfortunately, the IRS challenged the Tax Court decision and the Tax Court was later reversed by a federal appellate court.

Today, North Dakota has some 3.3 million acres with $110 million in rental payments in the CRP program. Left unchanged, the IRS's interpretation means that farmers in North Dakota will owe an additional $16 million in federal taxes this year. A typical North Dakota farmer with 160 acres in CRP would have a CRP payment of $5,280 and would owe nearly $800 in self-employment taxes because of the IRS's ill-advised position. If the IRS also decides to pursue back taxes on returns filed by farmers in past years, the amount of taxes owed by individuals farmers for CRP payments could amount to thousands of dollars.

I believe that it is absolutely wrong for the IRS to load up farmers with an added tax burden, especially when most of our Nation's family farmers are still struggling from day to day to make ends meet. With the legislation we are introducing today, Congress can tell the IRS that its effort to treat CRP payments as net earnings from self-employment is inappropriate and will not be allowed to stand.

Senator BROWNBACK and I ask our colleagues to support this much-needed tax relief for family farmers by cosponsoring the Conservation Reserve Program Tax Fairness Act. And we hope you will work with us to get this legislation enacted into law at the first available opportunity.

By Mr. SMITH (for himself, Mr. BIDEN, and Mr. DURBIN):

S. 1317. A bill to amend the American Servicemember's Protection Act of 2002 to provide clarification with respect to the eligibility of certain countries for United States military assistance; to the Committee on Armed Services.

Mr. SMITH. Mr. President, on behalf of myself and my colleagues Mr. BIDEN of Delaware and Mr. DURBIN of Illinois, I ask unanimous consent that the full text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1317

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. ELIGIBILITY OF CERTAIN COUNTRIES FOR UNITED STATES MILITARY ASSISTANCE.

(a) AMENDMENT.—Section 2007(d)(1) of the American Servicemembers' Protection Act of 2002 (title II of the 2002 Supplemental Appropriations Act for Further Recovery From and Response To Terrorist Attacks on the United States (Public Law 107–206; 116 Stat. 905)) is amended by inserting ''or a country that has concluded a protocol with NATO for the accession of the country to NATO'' before the semicolon.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) takes effect on July 1, 2003.

By Ms. SNOWE:

S. 1318. A bill to deauthorize the project for navigation, Tenants Harbor, Maine; to the Committee on Environment and Public Works.

By Ms. SNOWE:

S. 1319. A bill to deauthorize the project for navigation, Northeast Harbor, Maine; to the Committee on Environment and Public Works.

By Ms. SNOWE:

S. 1320. A bill to modify the project for navigation, Union River, Maine; to the Committee on Environment and Public Works.

Ms. SNOWE. Mr. President, I rise today to introduce three bills for harbors in Maine, two of them that will deauthorize the Federal Navigation Projects in Tenants Harbor and Northeast Harbor in Mt. Desert, and the third will redesignate the Upper Basin of the Union River Federal Navigational Channel in Ellsworth as an anchorage. The bills will help strengthen the economic viability of these three popular Maine harbors.

My first bill, S. 1318, pertains to Tenants Harbor, ME. Officials of the Town of Tenants Harbor have requested that the harbor be deauthorized. The original project was authorized in 1919, and was dredged that same year so that steamboats could access the Harbor. The channel has a width of 375 feet and extended out to 1,100 feet from Steamboat Wharf. Times have certainly changed as no steamboat has landed in the Harbor for 75 years. Over the years there have been mounting problems with the Army Corps of Engineers' mooring permit process as people seeking permits for moorings that have existed for 30 years continue to be notified that the mooring locations are prohibited because they fall within the Federal navigational channel. Deauthorizing the FNC would be of great help to the town in appropriately managing the Harbor to maximize mooring areas.

My second bill S. 1319 concerns Northeast Harbor in Mt. Desert, ME. The Town of Mount Desert has requested that Northeast Harbor be withdrawn from the Federal Navigation Project because of changing harbor usage over the last 45 years. This removal will allow the town to adapt to the high demand for moorings and will allow residents to obtain moorings in a more timely manner. The Harbor has now reached capacity for both moorings and shoreside facilities and has a waiting list of over sixty people, along with commercial operators who have been waiting for years to obtain a mooring for their commercial vessels.

The Harbor was authorized in 1945 and constructed in 1954 as a mixed-use commercial fishing/recreational boating harbor—and it still is today. It was dredged in the early 1950s to provide more space for recreational boating and the U.S. Army Corps of Engineers has informed the town that Northeast Harbor would be very low on its dredging priority list as it has become primarily a recreational harbor. The town says it realizes that, once it is no longer part of the Federal Navigational Project, any further dredging within the harbor would be carried out at town expense.

The language will not only allow for more recreational moorages and commercial activities, it will also be an economic boost to Northeast Harbor, which is surrounded by Acadia National Park, one of the nation's most visited parks—both by land and by water.

My third bill, S. 1320, addresses the Union River in Ellsworth, ME. The bill supports the City of Ellsworth's efforts to revitalize the Union River navigation channel, harbor, and shoreline. The modification called for in my legislation will redesignate a portion of the Union River as an anchorage area. This redesignation will allow for a greater number of moorings in the harbor without interfering with navigation and will further improve the city's revitalization efforts for the harbor area.

I have worked with the New England Division of the Corps to draft these bills and the language has been approved by Army Corps Headquarters in Washington. I look forward to working with my colleagues for their passage, either as stand alone bills or as separate provisions in the Corps reauthorization bill, the Water Resources Development Act of 2003, that Congress is currently drafting.

By Mr. GRASSLEY (for himself, Mr. LEAHY, and Mr. SESSIONS):

S. 1323. A bill to extend the period for which chapter 12 of title 11, United States Code, is reenacted by 6 months; read the first time.

Mr. GRASSLEY. Mr. President, I rise today to introduce a bill to extend Chapter 12 of the Bankruptcy Code until January 1, 2004. This measure will provide our family farmers with the necessary bankruptcy protections during hard times. However, I remain hopeful that the Senate will take up and pass the comprehensive bankruptcy legislation that the House passed not long ago. That bill makes Chapter 12 of the Bankruptcy Code permanent, so family farms are guaranteed the ability to reorganize. The bill also makes significant improvements to Chapter 12 so that it will be more accessible and helpful to farmers. So while I urge quick passage of this temporary Chapter 12 measure, I would like to see the comprehensive bankruptcy Reform bill and permanent Chapter 12 enacted into law as soon as possible. I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1323

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Family Farmer Bankruptcy Relief Act of 2003''.

SEC. 2. SIX-MONTH EXTENSION OF PERIOD FOR WHICH CHAPTER 12 OF TITLE 11, UNITED STATES CODE, IS REENACTED.

(a) AMENDMENTS.—Section 149 of title I of division C of Public Law 105–277 (11 U.S.C. 1201 note) is amended—

(1) by striking ''July 1, 2003'' each place it appears and inserting ''January 1, 2004''; and

(2) in subsection (a)—

(A) by striking ''December 31, 2002'' and inserting ''June 30, 2003''; and

(B) by striking ''January 1, 2003'' and inserting ''July 1, 2003''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on July 1, 2003.

By Mr. GRASSLEY (for himself and Mr. BAUCUS):

S. 1324. A bill to amend the Trade Act of 1974 to establish procedures for identifying countries that deny market access for agricultural products of the United States, and for other purposes; to the Committee on Finance.

Mr. GRASSLEY. Mr. President, I'm pleased to introduce today the United States Agricultural Products Market Access Act of 2003. This bill will be yet one more tool for the United States to use to expand its exports of agricultural products.

Agricultural exports are key to the economic health of rural America. Just last year, $53.1 billion worth of U.S.-produced agricultural products were exported. About one-third of America's farm products are sold outside of our borders. These sales in foreign markets translate to improved incomes for our country's farmers. Today, approximately one-fourth of gross farm income for U.S. producers comes from exports.

Agricultural exports are particularly important to farmers in my State of Iowa. In 2001, some $3.3 billion worth of Iowa's agricultural production was exported. This makes Iowa the second largest agricultural exporting State in the country. Iowa's largest commodities—corn, soybeans, pork, and beef—greatly benefit from sales abroad. Approximately one-half of U.S. soybean production, and 20 percent of our country's corn production, is exported. Last year U.S. pork exports set record levels. Since the implementation of the NAFTA, exports of U.S. beef and beef

variety meats to Mexico have increased five-fold. Iowa's producers clearly benefit from exports.

While Iowa's agricultural exports are already high, they have the potential to grow even more in coming years. Demand in the U.S. market for agricultural products is relatively stable. But populations, as well as disposable incomes, are increasing rapidly in foreign countries. With the hardest-working farmers and ranchers in the world, and with productivity increasing through improved technologies, the United States clearly has the ability to continue feeding a growing world.

But trade barriers imposed by foreign governments often cloud this bright spot for U.S. agriculture. Too frequently, misguided foreign governments overlook the wants and needs of their consumers and take measures to restrict, or prevent, imports of U.S. farm products. These policies hurt U.S. farmers. They also hurt foreign consumers.

In fact, due in part to foreign trade barriers, U.S. agricultural exports declined from $60.4 billion in 1996 to $53.1 billion in 2002.

Unfortunately, even countries that should be our closest trade allies are proving adept at imposing measures that block imports of U.S. farm products. As an example, our NAFTA-partner Mexico is imposing, or threatening to impose, barriers to imports of a wide variety of U.S. agricultural products. These products include corn, high fructose corn syrup, pork, beef, rice, apples, and dry beans. Iowa is a major producer of four of these products—corn, high fructose corn syrup, pork, and beef.

Not surprisingly, much of U.S. agriculture is upset with Mexico and other of our trading partners at this time. U.S. agricultural producers have traditionally been the strongest supporters of new trade deals. But due to foreign trade barriers, some in U.S. agriculture are beginning to question their support for new trade agreements.

The U.S. Trade Representative, in conjunction with Congress, is working hard to remove trade barriers imposed by Mexico and other countries. But the current tools available to the USTR, including negotiations, NAFTA challenges, and WTO challenges, don't always accomplish the job.

Let me give you an example. For several years now, Mexico has gone to great lengths to block imports of U.S.-produced high fructose corn syrup. In 1998, Mexico imposed antidumping duties on imports of this product from the United States. The United States challenged this antidumping order under the NAFTA. Mexico lost at the NAFTA. The United States challenged this order at the WTO. Mexico lost at the WTO. Following its defeats at the NAFTA and the WTO, Mexico revoked this antidumping order.

But, no, that wasn't the end of the story. Mexico turned around and imposed a 20 percent tax on sales of soft drinks containing high fructose corn syrup. This discriminatory tax was designed to boost sales of Mexican sugar at the expense of U.S.-produced high fructose corn syrup.

Mexico's tax in effect shut down the Mexican market for this product. Iowa's high fructose corn syrup producers are now being locked out of what was at one time their largest export market. This discriminatory tax is hurting Iowa's high fructose corn syrup producers. It's hurting Iowa's corn farmers.

This example clearly demonstrates that existing tools aren't always enough to remove entrenched trade barriers. Despite losing at the NAFTA, despite losing at the WTO, and despite lengthy negotiations, Mexico is still blocking imports of U.S. high fructose corn syrup.

It's time to add yet another tool to our arsenal.

That's why I'm introducing the United States Agricultural Products Market Access Act of 2003. This bill creates a new mechanism with which to confront foreign trade barriers. The new mechanism operates in a similar fashion to the existing special 301 provision for intellectual property. The bill requires USTR to identify and report on those foreign countries that deny fair and equitable market access for U.S. agricultural exports, or countries that apply to U.S. agricultural products sanitary or phytosanitary measures that are not based on sound science. USTR would annually issue a report on its findings.

Out of the countries identified in USTR's report, USTR would identify which ones have the most egregious practices impacting U.S. agricultural exports and, further, are not entering into good faith negotiations with the United States to end these practices.

This legislation also authorizes additional staffing for USTR to focus on these agricultural enforcement issues.

This bill will further strengthen the ability of the United States to enforce its existing market access rights for agricultural exports. Perhaps just as important, it will help Congress and the Administration prioritize barriers imposed by our trading partners. Through such prioritization, U.S. negotiators will be better able to focus upon removing the most egregious of these barriers.

The United States Agricultural Products Market Access Act will not solve all of our agricultural market access problems. We need to move ahead vigorously in bilateral and multilateral negotiations to tear down barriers to our exports. At the top of this list is successful completion of agricultural negotiations in the WTO. However, the United States Agricultural Products Market Access Act of 2003 will help us identify the most egregious problems, so we can focus our energy on fixing them. It will also provide a new enforcement tool to help make sure American farmers are getting the benefit of our hard fought trade bargains.

This bill is strongly supported by Iowa's agricultural community, including the Iowa Corn Growers, the Iowa Farm Bureau Federation, and the Iowa Soybean Association.

I would like to thank my distinguished colleagues Senator MAX BAUCUS, Ranking Member of the Finance Committee, and Representative DAVE CAMP for their hard work on this legislation.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1324

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''United States Agricultural Products Market Access Act of 2003''.

SEC. 2. FINDINGS; PURPOSES.

(a) FINDINGS.—Congress makes the following findings:

(1) The export of agricultural products is of vital importance to the economy of the United States.

(2) In 2002, agriculture was a large positive contributor to the United States merchandise trade balance with a trade surplus of $12,300,000,000.

(3) The growth of United States agricultural exports should continue to be an important factor in improving the United States merchandise trade balance.

(4) Increasing the volume of agricultural exports will increase farm income in the United States, thereby protecting family farms and contributing to the economic well-being of rural communities in the United States.

(5) Although the United States efficiently produces high-quality agricultural products, United States producers cannot realize their full export potential because many foreign countries deny fair and equitable market access to United States agricultural products.

(6) The Foreign Agricultural Service estimates that United States agricultural exports are reduced by $4,700,000,000 annually due to unjustifiable imposition of sanitary and phytosanitary measures that deny or limit market access to United States products.

(7) The denial of fair and equitable market access for United States agricultural products impedes the ability of United States farmers to export their products, thereby harming the economic interests of the United States.

(b) PURPOSES.—The purposes of this Act are—

(1) to reduce or eliminate foreign unfair trade practices and to remove constraints on fair and open trade in agricultural products;

(2) to ensure fair and equitable market access for exports of United States agricultural products; and

(3) to promote free and fair trade in agricultural products.

SEC. 3. IDENTIFICATION OF COUNTRIES THAT DENY MARKET ACCESS.

(a) IDENTIFICATION REQUIRED.—Chapter 8 of title I of the Trade Act of 1974 (19 U.S.C. 2241 et seq.) is amended by adding at the end the following:

''SEC. 183. IDENTIFICATION OF COUNTRIES THAT DENY MARKET ACCESS FOR AGRICULTURAL PRODUCTS.

''(a) IN GENERAL.—Not later than the date that is 30 days after the date on which the

annual report is required to be submitted to Congressional committees under section 181(b), the United States Trade Representative (in this section referred to as the 'Trade Representative') shall identify—

''(1) those foreign countries that—

''(A) deny fair and equitable market access to United States agricultural products, or

''(B) apply standards for the importation of agricultural products from the United States that are not related to public health concerns or cannot be substantiated by reliable analytical methods, and

''(2) those foreign countries identified under paragraph (1) that are determined by the Trade Representative to be priority foreign countries.

''(b) SPECIAL RULES FOR IDENTIFICATIONS.—

''(1) CRITERIA.—In identifying priority foreign countries under subsection (a)(2), the Trade Representative shall only identify those foreign countries—

''(A) that engage in or have the most onerous or egregious acts, policies, or practices that deny fair and equitable market access to United States agricultural products,

''(B) whose acts, policies, or practices described in subparagraph (A) have the greatest adverse impact (actual or potential) on the relevant United States products, and

''(C) that are not—

''(i) entering into good faith negotiations, or

''(ii) making significant progress in bilateral or multilateral negotiations,

to provide fair and equitable market access to United States agricultural products.

''(2) CONSULTATION AND CONSIDERATION REQUIREMENTS.—In identifying priority foreign countries under subsection (a)(2), the Trade Representative shall—

''(A) consult with the Secretary of Agriculture and other appropriate officers of the Federal Government, and

''(B) take into account information from such sources as may be available to the Trade Representative and such information as may be submitted to the Trade Representative by interested persons, including information contained in reports submitted under section 181(b) and petitions submitted under section 302.

''(3) FACTUAL BASIS REQUIREMENT.—The Trade Representative may identify a foreign country under subsection (a)(1) only if the Trade Representative finds that there is a factual basis for the denial of fair and equitable market access as a result of the violation of international law or agreement, or the existence of barriers, referred to in subsection (d).

''(4) CONSIDERATION OF HISTORICAL FACTORS.—In identifying foreign countries under paragraphs (1) and (2) of subsection (a), the Trade Representative shall take into account—

''(A) the history of agricultural trade relations with the foreign country, including any previous identification under subsection (a)(2), and

''(B) the history of efforts of the United States, and the response of the foreign country, to achieve fair and equitable market access for United States agricultural products.

''(c) REVOCATIONS AND ADDITIONAL IDENTIFICATIONS.—

''(1) AUTHORITY TO ACT AT ANY TIME.—If information available to the Trade Representative indicates that such action is appropriate, the Trade Representative may at any time—

''(A) revoke the identification of any foreign country as a priority foreign country under this section, or

''(B) identify any foreign country as a priority foreign country under this section.

''(2) REVOCATION REPORTS.—The Trade Representative shall include in the semiannual report submitted to the Congress under section 309(3) a detailed explanation of the reasons for the revocation under paragraph (1) of the identification of any foreign country as a priority foreign country under this section.

''(d) DENIAL OF FAIR AND EQUITABLE MARKET ACCESS DEFINED.—For purposes of this section, a foreign country denies fair and equitable market access if the foreign country effectively denies access to a market for a product through the use of laws, procedures, practices, or regulations which—

''(1) violate provisions of international law or international agreements to which both the United States and the foreign country are parties, or

''(2) constitute discriminatory nontariff trade barriers.

''(e) PUBLICATION.—The Trade Representative shall publish in the Federal Register a list of foreign countries identified under subsection (a) and shall make such revisions to the list as may be required by reason of the action under subsection (c).

''(f) ANNUAL REPORT.—The Trade Representative shall, not later than the date by which countries are identified under subsection (a), transmit to the Committee on Ways and Means and the Committee on Agriculture of the House of Representatives and the Committee on Finance and the Committee on Agriculture, Nutrition, and Forestry of the Senate, a report on the actions taken under this section during the 12 months preceding such report, and the reasons for such actions, including a description of progress made in achieving fair and equitable market access for United States agricultural products.''.

(b) CLERICAL AMENDMENT.—The table of contents for the Trade Act of 1974 is amended by inserting after the item relating to section 182 the following:

''Sec. 183. Identification of countries that deny market access for agricultural products.''.

(c) ADDITIONAL STAFF FOR OFFICE OF ASSISTANT TRADE REPRESENTATIVE FOR AGRICULTURAL AFFAIRS AND OFFICE OF ASSISTANT TRADE REPRESENTATIVE FOR MONITORING AND ENFORCEMENT.—

(1) IN GENERAL.—There is authorized to be appropriated such sums as may be necessary for fiscal year 2004 for the salaries and expenses of 1 additional specialist employee position within the Office of the Assistant United States Trade Representative for Agricultural Affairs and 1 additional specialist employee position within the Office of the Assistant United States Trade Representative for Monitoring and Enforcement.

(2) AVAILABILITY.—Amounts appropriated pursuant to the authorization of appropriations under paragraph (1) are authorized to remain available until expended.

SEC. 4. INVESTIGATIONS.

(a) INVESTIGATION REQUIRED.—Subparagraph (A) of section 302(b)(2) of the Trade Act of 1974 (19 U.S.C. 2412(b)(2)) is amended by inserting ''or 183(a)(2)'' after ''section 182(a)(2)'' in the matter preceding clause (i).

(b) CONFORMING AMENDMENT.—Subparagraph (D) of section 302(b)(2) of such Act is amended by inserting ''concerning intellectual property rights that is'' after ''any investigation''.

By Mr. BURNS (for himself, Mr. GRAHAM of South Carolina, Mr. HAGEL, and Mr. FITZGERALD):

S. 1325. A bill to amend the National Highway System Designation Act of 1995 to modify the applicability of requirements concerning hours of service to operators of commercial motor vehicles transporting agricultural commodities and farm supplies; to the Committee on Commerce, Science, and Transportation.

Mr. BURNS. Mr. President, today I am introducing legislation that will protect an existing exemption for farmers and agribusinesses from the Department of Transportation's, DOT, limitations on maximum driving time in transporting agricultural commodities or farm supplies during peak planting and growing seasons.

In 1995, Public Law 104–59 passed by Congress granted farmers and retail farm suppliers a limited exemption from DOT limitations on maximum driving time in transporting agricultural commodies or farm supplies within a 100-mile radius of a final distribution point. This legislation recognized the special needs of rural America, understanding that drivers employed by farm retailers generally operate in local areas to farmers' fields delivering and applying crop inputs. Much of their time is spent waiting at the field or the farm store loading and unloading their trucks. In short, farm retail drivers stay in a local area and return to their homes each night to sleep. The work of these crop input suppliers is essential to the Nation's farmers, who often have short windows of time to plant and harvest their crop around changing weather patterns.

The agricultural exemption is seasonal, applying only during designated months throughout the year as determined by each State. Every State has now taken this action, and to my knowledge this exemption has not had any impact on public safety.

It is important to note that under my clarifying legislation, the farm supply/farm commodity exemption would remain limited in scope.

My legislation reiterates original Congressional support for the agricultural exemption. The DOT has no expertise in this area nor, in my opinion, does the definition of agricultural commodity come under the jurisdiction of this agency. In addition, the term ''agricultural commodity'' is already defined by Section 102 of the Agricultural Trade Act of 1978 (7 U.S.C. 5602). Therefore, in my legislation, Section 345 (e) of the National Highway System Designation Act of 1995 is amended to reflect the definition in the Agricultural Trade Act.

A bipartisan group of House Members are also seeking clarifying legislation in this regard with Representative BEREUTER of Nebraska taking the lead.

I urge all my colleagues to join me in passing this legislation to protect the agricultural exemption to hours of service rules and prevent DOT from diminishing or revoking the exemption.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 181—CONGRATULATING ALL NEW YORKERS ON THE OCCASION OF THEIR FIRST KENTUCKY DERBY VICTORY AND THE SUBSEQUENT PREAKNESS STAKES VICTORY WITH NEW YORK-BRED GELDING, FUNNY CIDE

Mr. SCHUMER (for himself and Mrs. CLINTON) submitted the following resolution; which was referred to the Committee on the Judiciary:

S. RES. 181

Whereas on Saturday, May 3, 2003, Funny Cide won the 129th Kentucky Derby by 1¾ lengths, with a time of 2:01:19, and became the first New York-bred horse to win the Run for the Roses and the first gelding to win the Derby since Clyde Van Dusen in 1929;

Whereas on Saturday, May 17, 2003, Funny Cide won the 128th Preakness Stakes by 9¾ lengths, with a time of 1:55:61, and became the first New York-bred horse in 107 years, and the first gelding since Prairie Bayou in 1993, to win the Preakness;

Whereas Funny Cide is the great-great grandson of the 1977 Triple Crown winner, Seattle Slew;

Whereas Funny Cide was trained by Barclay Tagg and ridden by jockey Jose Santos;

Whereas high school friends from Sackets Harbor, New York, along with friends made thereafter, are the proud owners of Funny Cide,

Whereas Funny Cide races out of Sackatoga Stables, named after the hometown of the original owners — Sacket Harbor, New York — and the home of another owner — Saratoga Springs, New York; and

Whereas Funny Cide, a horse with a reputation as being ''from the wrong side of the track'', has become the pride and joy of all New Yorkers: Now, therefore, be it

Resolved, That the Senate—

(1) congratulates Sackatoga Stables for Funny Cide's victories at the 129th Kentucky Derby and the 128th Preakness Stakes; and

(2) directs the Secretary of the Senate to make available enrolled copies of this resolution for appropriate display to the owners of Funny Cide, trainer Barclay Tagg, and jockey Jose Santos.

SENATE RESOLUTION 182—CONGRATULATING THE AMERICAN DENTAL ASSOCIATION FOR ESTABLISHING THE ''GIVE KIDS A SMILE'' PROGRAM, EMPHASIZING THE NEED TO IMPROVE ACCESS TO DENTAL CARE FOR CHILDREN, AND THANKING DENTISTS FOR VOLUNTEERING THEIR TIME TO HELP PROVIDE NEEDED DENTAL CARE

Ms. STABENOW submitted the following resolution; which was referred to the Committee on Health, Education, Labor, and Pensions:

S. RES. 182

Whereas access to dental care for children is a vital element of overall health care and development;

Whereas dental caries—more commonly known as tooth decay—is the most common chronic childhood disease;

Whereas untreated tooth decay in children results in thousands of children experiencing poor eating and sleeping patterns, suffering decreased attention spans at school, and being unable to smile;

Whereas, due to a confluence of factors, children eligible for Medicaid and the State Children's Health Insurance Program are 3 to 5 times more likely than other children to have untreated tooth decay;

Whereas dentists provide an estimated $1,700,000,000 annually in nonreimbursed dental care;

Whereas dentists participating in the American Dental Association established the ''Give Kids a Smile'' program to serve as a reminder to the Nation about the need to end untreated childhood dental disease; and

Whereas the ''Give Kids a Smile'' program treated an estimated 1,000,000 children on February 21, 2003, at approximately 5,000 locations in all 50 States: Now, therefore, be it

Resolved, That the Senate—

(1) congratulates the American Dental Association for establishing the ''Give Kids a Smile'' program;

(2) emphasizes the need to improve access to dental care for children; and

(3) thanks the thousands of dentists who volunteered their time and brought a smile to faces of an estimated 1,000,000 children on February 21, 2003.

Ms. STABENOW. Mr. President, someone once said, ''A smile costs nothing, but gives much. It enriches those who receive, without making poorer those that give.'' I rise today to offer a resolution to congratulate the American Dental Association for establishing the ''Give Kids a Smile'' program.

This program emphasizes the need to improve dental care access for children. Tooth decay is the most common chronic childhood disease. Tooth decay can cause poor eating and sleeping patterns, decreased attention spans at school, and sadly, prevents children from showing their smiles.

Low income children are much more likely to suffer from tooth decay. Children who are eligible for Medicaid and State Children's Health Insurance Program, SCHIP, are 3 to 5 times more likely than other children to have untreated tooth decay. The ''Give Kids a Smile'' program is helping these children.

Along with helping children get the dental care that they need, this program brings attention to the fact that this is a serious issue that children in our nation are facing. This program provides for and promotes education on dental care, good dental hygiene, dental screenings, exams and radiographs, and even gives sealants and fillings.

On February 21st, my State, Michigan, brought healthier teeth and brighter smiles to 12,800 low-income and disadvantage children. Nearly 1 million children were treated nationwide.

Dentists, such as Dr. John Buchheister, Dr. Sara Wassenaar, Dr. Dale Nester, Dr. Martha Bamfield, and Dr. Gary Schluckebier in Michigan, volunteered their time, resources, and services to give children dental screenings, exams, sealants, and fillings.

Nearly 8,300 children in Michigan also listened to dental education presentations by dental professionals.

I am pleased to stand here today and congratulate the American Dental Association for their leadership on this important children's health issue and for establishing the ''Give Kids a Smile'' program.

I also want to thank the Michigan Dental Association for participating in this program and I want to thank all of the dentists in Michigan and across the Nation that took the time to make the inaugural ''Give Kids a Smile'' day a great success. After all, ''A smile can open a heart faster than a key can open a door.''

AMENDMENTS SUBMITTED & PROPOSED

SA 1001. Mrs. BOXER (for herself and Ms. MIKULSKI) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

SA 1002. Mrs. LINCOLN (for herself, Mr. CONRAD, Mr. MILLER, Mr. CARPER, Mr. JOHNSON, Ms. MIKULSKI, Mrs. CLINTON, and Mr. DORGAN) proposed an amendment to the bill S. 1, supra.

SA 1003. Mr. BROWNBACK (for himself and Mr. NELSON, of Nebraska) submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1004. Mrs. HUTCHISON proposed an amendment to the bill S. 1, supra.

SA 1005. Mr. SANTORUM submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1006. Mr. SANTORUM submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1007. Mr. SANTORUM submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1008. Mr. SANTORUM submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1009. Mr. INOUYE (for himself and Mr. AKAKA) submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1010. Mr. SUNUNU submitted an amendment intended to be proposed by him to the bill S. 1, supra.

SA 1011. Mr. SESSIONS proposed an amendment to the bill S. 1, supra.

SA 1012. Mr. HAGEL (for himself and Mr. ENSIGN) submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1013. Mr. BOND (for himself and Mr. ROBERTS) submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1014. Mr. BOND submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1015. Mr. DODD submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1016. Mrs. CLINTON submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1017. Mr. ALLARD (for himself, Mr. FITZGERALD, and Ms. COLLINS) submitted an

amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1018. Mr. LIEBERMAN (for himself and Ms. COLLINS) submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1019. Mr. CONRAD (for himself, Mrs. MURRAY, Mr. SMITH, Mrs. LINCOLN, and Mr. JEFFORDS) proposed an amendment to the bill S. 1, supra.

SA 1020. Mr. CONRAD proposed an amendment to the bill S. 1, supra.

SA 1021. Mr. CONRAD proposed an amendment to the bill S. 1, supra.

SA 1022. Mr. BROWNBACK submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1023. Ms. COLLINS submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1024. Mr. ENSIGN (for himself and Mrs. LINCOLN) submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1025. Mr. ENSIGN submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1026. Mr. HAGEL (for himself, Mr. ENSIGN, Mr. LOTT, and Mr. INHOFE) submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1027. Ms. SNOWE submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1028. Mr. CRAIG submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1029. Mr. SANTORUM submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1030. Mr. ENZI submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1031. Mr. CARPER submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1032. Ms. MIKULSKI submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1033. Ms. MIKULSKI submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1034. Ms. MIKULSKI submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1035. Ms. MIKULSKI submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1036. Mr. REID (for Mrs. BOXER) proposed an amendment to the bill S. 1, supra.

SA 1037. Mr. REID (for Mr. CORZINE) proposed an amendment to the bill S. 1, supra.

SA 1038. Mr. REID (for Mr. JEFFORDS) proposed an amendment to the bill S. 1, supra.

SA 1039. Mr. REID (for Mr. INOUYE) proposed an amendment to the bill S. 1, supra.

SA 1040. Mr. SCHUMER (for himself, Mr. CORZINE, Mrs. CLINTON, and Mr. LAUTENBERG) submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1041. Ms. MURKOWSKI (for herself and Mr. STEVENS) submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1042. Ms. MURKOWSKI (for herself and Mr. STEVENS) submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1043. Mr. ALLARD submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 1001. Mrs. BOXER (for herself and Ms. MIKULSKI) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

On page 49, strike line 3 through page 50, line 2 and insert the following:

''(2) LIMITS ON COST-SHARING.—

''(A) IN GENERAL.—The coverage has cost-sharing (for costs above the annual deductible specified in paragraph (1) and up to the annual out-of-pocket limit under paragraph (4)) that is equal to 50 percent or that is actuarially consistent (using processes established under subsection (f)) with an average expected payment of 50 percent of such costs.

''(B) APPLICATION.—Notwithstanding the succeeding provisions of this part, the Administrator shall not apply subsection (d)(1)(C) and paragraphs (1)(D), (2)(D), and (3)(A)(iv) of section 1860D–19(a).

SA 1002. Mrs. LINCOLN (for herself, Mr. CONRAD, Mr. MILLER, Mr. CARPER, Mr. JOHNSON, Ms. MIKULSKI, Mrs. CLINTON, and Mr. DORGAN) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

On page 83, strike lines 1 through 7, and insert the following:

''(5) CONTRACT TO BE AVAILABLE IN DESIGNATED AREA FOR 2 YEARS.—Notwithstanding paragraph (1), if the Administrator enters into a contract with an entity with respect to an area designated under subparagraph (B) of such paragraph for a year, the following rules shall apply:

''(A) The contract shall be for a 2-year period.

''(B) The Secretary is not required to make the determination under paragraph (1)(A) with respect to the second year of the contract for the area.

''(C) During the second year of the contract, an eligible beneficiary residing in the area may continue to receive standard prescription drug coverage (including access to negotiated prices for such beneficiaries pursuant to section 1860D–6(e)) under such contract or through any Medicare Prescription Drug plan that is available in the area.

At the end of title VI, add the following:

SEC. ___. MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking ''promptly (as determined in accordance with regulations)'';

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

''(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

(b) CLARIFYING AMENDMENTS TO CONDITIONAL PAYMENT PROVISIONS.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: ''An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.'';

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: ''A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.''; and

(B) in the final sentence, by striking ''on the date such notice or other information is received'' and inserting ''on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received''; and

(3) in subparagraph (B)(iii), , as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: ''In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.''.

(c) CLERICAL AMENDMENTS.—Section 1862(b)(42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking ''such'' before ''paragraphs''.

SA 1003. Mr. BROWNBACK (for himself and Mr. NELSON of Nebraska) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, insert the following:

SEC. .RURAL COMMUNITY HOSPITAL ASSISTANCE.

(a) ESTABLISHMENT OF RURAL COMMUNITY HOSPITAL (RCH) PROGRAM.

(1) IN GENERAL.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end of the following new subsection: ''Rural Community Hospital; Rural Community Hospital Services ''(ww)(1) The term 'rural community hospital' means a hospital (as defined in subsection (e)) that—

''(A) is located in a rural area (as defined in section 1886(d)(2)(D)) or treated as being so located pursuant to section 1886(d)(8)(E);

''(B) subject to paragraph (2), has less than 51 acute care inpatient beds, as reported in its most recent cost report; 10

''(C) makes available 24-hour emergency care services;

''(D) subject to paragraph (3), has a provider agreement in effect with the Secretary and is open to the public as of January 1, 2003; and

''(E) applies to the Secretary for such designation.

''(2) For purposes of paragraph (1)(B), beds in a psychiatric or rehabilitation unit of the hospital which is a distinct part of the hospital shall not be counted.

''(3) Subparagraph (1)(D) shall not be construed to prohibit any of the following from qualifying as a rural community hospital:

''(A) A replacement facility (as defined by the Secretary in regulations in effect on January 1, 2003) with the same service area (as defined by the Secretary in regulations in effect on such date).

''(B) A facility obtaining a new provider number pursuant to a change of ownership.

''(C) A facility which has a binding written agreement with an outside, unrelated party for the construction, reconstruction, lease, rental, or financing of a building as of January 1, 2003.

''(4) Nothing in this subsection shall be construed as prohibiting a critical access hospital from qualifying as a rural community hospital if the critical access hospital meets the conditions otherwise applicable to hospitals under subsection (e) and section 1866.''.

(2) PAYMENT.—

(A) INPATIENT SERVICES.—Section 1814 (42 U.S.C. 1395f) is amended by adding at the end the following new subsection: ''Payment for Inpatient Services Furnished in Rural Community Hospitals

''(m) The amount of payment under this part for inpatient hospital services furnished in a rural community hospital, other than such services furnished in a psychiatric or rehabilitation unit of the hospital which is a distinct part, is, at the election of the hospital in the application referred to in section 1861(ww)(1)(E)—

''(1) the reasonable costs of providing such services, without regard to the amount of the customary or other charge, or

''(2) the amount of payment provided for under the prospective payment system for inpatient hospital services under section 1886(d).''.

(B) OUTPATIENT SERVICES.—Section 1834 (42 U.S.C. 1395m) is amended by amended by adding at the end the following new subsection:

''(n) PAYMENT FOR OUTPATIENT SERVICES FURNISHED IN RURAL COMMUNITY HOSPITALS.—The amount of payment under this part for outpatient services furnished in a rural community hospital is, at the election of the hospital in the application referred to in section 1861(ww)(1)(E)—

''(1) the reasonable costs of providing such services, without regard to the amount of the customary or other charge and any limitation under section 1861(v)(1)(U), or

''(2) the amount of payment provided for under the prospective payment system for covered OPD services under section 1833(t).''.

(C) HOME HEALTH SERVICES.—

(i) EXCLUSION FROM HOME HEALTH PPS.—Section 1895 (42 U.S.C. 1395fff) is amended by adding at the end the following:

''(f) EXCLUSION.—

''(1) IN GENERAL.—In determining payments under this title for home health services furnished on or after October 1, 2003, by a qualified RCH-based home health agency (as defined in paragraph (2))—

''(A) the agency may make a one-time election to waive application of the prospective payment system established under this section to such services furnished by the agency shall not apply; and

''(B) in the case of such an election, payment shall be made on the basis of the reasonable costs incurred in furnishing such services as determined under section 1861(v), but without regard to the amount of the customary or other charges with respect to such services or the limitations established under paragraph (1)(L) of such section.

''(2) QUALIFIED RCH-BASED HOME HEALTH AGENCY DEFINED.—For purposes of paragraph (1), a 'qualified RCH-based home health agency' is a home health agency that is a provider-based entity (as defined in section 404 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Public Law 106–554; Appendix F, 114 Stat. 2763A–506)) of a rural community hospital that is located—

''(A) in a county in which no main or branch office of another home health agency is located; or

''(B) at least 35 miles from any main or branch office of another home health agency.''.

(ii) CONFORMING CHANGES.—

(I) PAYMENTS UNDER PART A.—Section 1814(b) (42 U.S.C. 1395f(b)) is amended by inserting ''or with respect to services to which section 1895(f) applies'' after ''equipment'' in the matter preceding paragraph (1).

(II) PAYMENTS UNDER PART B.—Section 1833(a)(2)(A) (42 U.S.C. 13951(a)(2)(A)) is amended by striking ''the prospective payment system under''.

(III) PER VISIT LIMITS.—Section 1861(v)(1)(L)(i) (42 U.S.C. 1395x(v)(1)(L)(i)) is amended by inserting ''(other than by a qualified RCH-based home health agency (as defined in section 1895(f)(2))'' after ''with respect to services furnished by home health agencies''.

(iii) CONSOLIDATED BILLING.—

(I) RECIPIENT OF PAYMENT.—Section 1842(b)(6)(F) (42 U.S.C. 1395u(b)(6)(F)) is amended by inserting ''and excluding home health services to which section 1895(f) applies'' after ''provided for in such section''.

(II) EXCEPTION TO EXCLUSION FROM COVERAGE.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended by inserting before the period at the end of the second sentence the following: ''and paragraph (21) shall not apply to home health services to which section 1895(f) applies''.

(D) RETURN ON EQUITY.—Section 1861(v)(1)(P) (42 U.S.C. 1395x(v)(1)(P)) is amended—

(i) by inserting ''(i)'' after ''(P)''; and

(ii) by adding at the end the following:

''(ii)(I) Notwithstanding clause (i), subparagraph (S)(i), and section 1886(g)(2), such regulations shall provide, in determining the reasonable costs of the services described in subclause (II) furnished by a rural community hospital on or after October 1, 2003, for payment of a return on equity capital at a rate of return equal to 150 percent of the average specified in clause (i).

''(11) The services referred to in subelause (I) are inpatient hospital services, outpatient hospital services, home health services furnished by an RCH-based home health agency (as defined in section 1895(f)(2)), and ambulance services.

''(III) Payment under this clause shall be made without regard to whether a provider is a proprietary provider.''.

(E) EXEMPTION FROM 30 PERCENT REDUCTION IN REIMBURSEMENT FOR BAD DEBT.—Section 1861(v)(1)(T) (42 U.S.C.1395x(v)(1)(T)) is amended by inserting ''(other than a rural community hospital)'' after ''In determining such reasonable costs for hospitals''.

(3) BENEFICIARY COST-SHARING FOR OUTPATIENT SERVICES.—Section 1834(n) (as added by paragraph (2)(B)) is amended—

(A) by inserting ''(1)'' after ''(n)''; and

(B) by adding at the end the following:

''(2) The amounts of beneficiary cost-sharing for outpatient services furnished in a rural community hospital under this part shall be as follows:

''(A) For items and services that would have been paid under section 1833(t) if provided by a hospital, the amount of cost-sharing determined under paragraph (8) of such section.

''(B) For items and services that would have been paid under section 1833(h) if furnished by a provider or supplier, no cost-sharing shall apply.

''(C) For all other items and services, the amount of cost-sharing that would apply to the item or service under the methodology that would be used to determine payment for such item or service if provided by a physician, provider, or supplier, as the case may be.''.

(4) CONFORMING AMENDMENTS.—

(A) PART A PAYMENT.—Section 1814(b) (42 U.S.C. 1395f(b)) is amended by inserting ''other than inpatient hospital services furnished by a rural community hospital,'' after ''critical access hospital services,''.

(B) PART B PAYMENT.—

(i) IN GENERAL.—Section 1833(a) (42 U.S.C. 13951(a)) is amended—

(I) in paragraph (2), in the matter before subparagraph (A), by striking ''and (I)'' and inserting ''(I), and (K)'';

(II) by striking ''and'' at the end of paragraph (8);

(III) by striking the period at the end of paragraph (9) and inserting ''; and''; and

(IV) by adding at the end the following:

''(10) in the case of outpatient services furnished by a rural community hospital, the amounts described in section 1834(n).''.

(ii) AMBULANCE SERVICES.—Section 1834(l)(8) (42 U.S.C. 1395m(1)(8)), as added by section 205 (a) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Appendix F, 114 Stat. 2763A–463), as enacted into law by section 1(a)(6) of Public Law 106–554, is amended—

(I) in the heading, by striking ''CRITICAL ACCESS HOSPITALS'' and inserting ''CERTAIN FACILITIES'';

(II) by striking ''or'' at the end of subparagraph (A);

(III) by redesignating subparagraph (B) as subparagraph (C);

(IV) by inserting after subparagraph (A) the following new subparagraph:

''(B) by a rural community hospital (as defined in section 1861(ww)(1)), or''; and (V) in subparagraph (C), as so redesignated, by inserting ''or a rural community hospital'' after ''critical access hospital''.

(C) TECHNICAL AMENDMENTS.—

(1) CONSULTATION WITH STATE AGENCIES.—Section 1863 (42 U.S.C. 1395z) is amended by striking ''and (dd)(2)'' and inserting ''(dd)(2), (mm)(1), and (ww)(1)''.

(ii) PROVIDER AGREEMENTS.—Section 1866(a)(2)(A) (42 U.S.C. 1395cc(a)(2)(A)) is amended by inserting ''section 1834(n)(2),'' after ''section 1833(b),''.

(iii) BIPA AMENDMENT.—Paragraph (8) of section 1834(1) (42 U.S.C. 1395m(1)), as added by section 221 (a) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Appendix F, 114 Stat. 2763A–486), as enacted into law by section 1(a)(6) of Public Law 106–554, is redesignated as paragraph (9).

(5) EFFECTIVE DATE.—The amendments made by this subsection shall apply to items and services furnished on or after October 1, 2003.

(b) REMOVING BARRIERS TO ESTABLISHMENT OF DISTINCT PART UNITS BY RCH AND CAH FACILITIES.—

(1) IN GENERAL.—Section 1886(d)(1)(B) (42 U.S.C. 1395ww(d)(1)(B)) is amended by striking ''a distinct part of the hospital (as defined by the Secretary)'' in the matter following clause (v) and inserting ''a distinct part (as defined by the Secretary) of the hospital or of a critical access hospital or a rural community hospital''.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to determinations with respect to distinct part unit status that are made on or after October 1, 2003.

(c) IMPROVEMENTS TO MEDICARE CRITICAL ACCESS HOSPITAL (CAH) PROGRAM.—

(1) EXCLUSION OF CERTAIN BEDS FROM BED COUNT.—Section 1820(c)(2) (42 U.S.C. 1395i–4(c)(2)) is amended by adding at the end the following:

''(E) EXCLUSION OF CERTAIN BEDS FROM BED COUNT.—In determining the number of beds of a facility for purposes of applying the bed limitations referred to in subparagraph (B)(iii) and subsection (f), the Secretary shall not take into account any bed of a distinct part psychiatric or rehabilitation unit (described in the matter following clause (v) of section 1886(d)(1)(B)) of the facility, except that the total number of beds that are not taken into account pursuant to this subparagraph with respect to a facility shall not exceed 10.''.

(2) PAYMENTS TO HOME HEALTH AGENCIES OWNED AND OPERATED BY A CAH.—Section 1895(f) (42 U.S.C. 1395fff(f)), as added by subsection (a)(2)(C), is further amended by inserting ''or by a home health agency that is owned and operated by a critical access hospital (as defined in section 1861(mm)(1))'' after ''as defined in paragraph (2))''.

(3) PAYMENTS TO CAH-OWNED SNFS.—

(A) IN GENERAL.—Section 1888(e)(42 U.S.C. 1395yy(e)) is amended—

(i) in paragraph (1), by striking ''and (12)'' and inserting ''(12), and (13)''; and

(ii) by adding at the end thereof the following:

''(13) EXEMPTION OF CAH FACILITIES FROM PPS.—In determining payments under this part for covered skilled nursing facility services furnished on or after October 1, 2003, by a skilled nursing facility that is a distinct part unit of a critical access hospital (as defined in section 1861(mm)(1)) or is owned and operated by a critical access hospital—

''(A) the prospective payment system established under this subsection shall not apply; and

''(B) payment shall be made on the basis of the reasonable costs incurred in furnishing such services as determined under section 1861(v), but without regard to the amount of the customary or other charges with respect to such services or the limitations established under subsection (a).''.

(B) CONFORMING CHANGES.—

(i) IN GENERAL.—Section 1814(b) (42 U.S.C. 1395f(b)), as amended by subsection (a), is further amended in the matter preceding paragraph (1)—

(I) by inserting ''other than a skilled nursing facility providing covered skilled nursing facility services (as defined in section 1888(e)(2)) or post hospital extended care services to which section 1888(e)(13) applies,'' after ''inpatient critical access hospital services''; and

(II) by striking ''1813 1886,'' and inserting ''1813, 1886, 1888,''.

(i) CONSOLIDATED BILLING.—

(I) RECIPIENT OF PAYMENT.—Section 1842(b)(6)(E) (42 U.S.C. 1395u(b)(6)(E)) is amended by inserting ''services to which paragraph (7)(C) or (13) of section 1888(e) applies and'' after ''other than''.

(II) EXCEPTION TO EXCLUSION FROM COVERAGE.—Section 1862(a)(18) (42 U.S.C. 1395y(a)(18)) is amended by inserting ''(other than services to which paragraph (7)(C) or (13) of section 1888(e) applies)'' after ''section 1888(e)(2)(A)(i)''.

(4) PAYMENTS TO DISTINCT PART PSYCHIATRIC OR REHABILITATION UNITS OF CAHS.—Section 1886(b) (42 U.S.C. 1395ww(b)) is amended—

(A) in paragraph (1), by inserting '', other than a distinct part psychiatric or rehabilitation unit to which paragraph (8) applies,'' after ''subsection (d)(1)(B)''; and

(B) by adding at the end the following:

''(8) EXEMPTION OF CERTAIN DISTINCT PART PSYCHIATRIC OR REHABILITATION UNITS FROM COST LIMITS.—In determining payments under this part for inpatient hospital services furnished on or after October 1, 2003, by a distinct part psychiatric or rehabilitation unit (described in the matter following clause (v) of subsection (d)(1)(B)) of a critical access hospital (as defined in section 1861(mm)(1))—

''(A) the limits imposed under the preceding paragraphs of this subsection shall not apply; and

''(B) payment shall be made on the basis of the reasonable costs incurred in furnishing such services as determined under section 1861(v), but without regard to the amount of the customary or other charges with respect to such services.''.

(5) RETURN ON EQUITY.—Section 1861(v)(1)(P) (42 U.S.C. 1395x(v)(1)(P)), as amended by subsection (a)(2)(D), is further amended by adding at the end the following:

''(111)(I) Notwithstanding clause (i), subparagraph (S)(i), and section 1886(8)(2), such regulations shall provide, in determining the reasonable costs of the services described in subclause (II) furnished by a critical access hospital on or after October 1, 2003, for payment of a return on equity capital at a rate of return equal to 150 percent of the average specified in clause (i).

''(II) The services referred to in subclause (I) are inpatient critical access hospital services (as defined in section 1861(mm)(2)), outpatient critical access hospital services (as defined in section 1861(mm)(3)), extended care services provided pursuant to an agreement under section 1883, posthospital extended care services to which section 1888(e)(13) applies, home health services to which section 1895(f) applies, ambulance services to which section 1834(l) applies, and inpatient hospital services to which section 1886(b)(8) applies.

''(III) Payment under this clause shall be made without regard to whether a provider is a proprietary provider.''.

(6) TECHNICAL CORRECTIONS.—

(A) SECTION 403(b) OF BBRA 1999.—Section 1820(b)(2) (42 U.S.C. 1395i–4(b)(2)) is amended by striking ''nonprofit or public hospitals'' and inserting ''hospitals''.

(B) SECTION 203(b) OF BIPA 2000.—Section 1883(a)(3) (42 U.S.C. 1395tt(a)(3)) is amended—

(i) by inserting ''section 1861(v)(1)(G) or'' after ''Notwithstanding''; and

(ii) by striking ''covered skilled nursing facility''.

(9) EFFECTIVE DATES.—

(A) ELIMINATION OF REQUIREMENTS.—The amendments made by paragraphs (1) and (2) shall apply to services furnished on or after October 1, 2003.

(B) TECHNICAL CORRECTIONS.—

(i) BBRA.—The amendment made by paragraph (6)(A) shall be effective as if included in the enactment of section 403(b) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (Appendix F, 113 Stat. 1501A–321), as enacted into law by section 1000(a)(6) of Public Law 106–113.

(ii) BIPA.—The amendments made by paragraph (6)(B) shall be effective as if included in the enactment of section 203(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Appendix F, 114 Stat. 2763A–463), as enacted into law by section 1(a)(6) of Public Law 106–554.

SA 1004. Mrs. HUTCHISON proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end of subtitle A of title IV, add the following:

SEC. ___. FREEZING INDIRECT MEDICAL EDUCATION (IME) ADJUSTMENT PERCENTAGE AT 6.5 PERCENT.

(a) IN GENERAL.—Section 1886(d)(5)(B)(ii)(42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended—

(1) in subclause (VI), by striking ''and'' at the end; and

(2) by striking subclause (VII) and inserting the following new subclauses:

''(VII) during fiscal years 2003, 2004, 2005, 2006, 2007 and 2008, 'c' is equal to 1.35; and

''(VIII) on or after October 1, 2008, 'c' is equal to 1.6.''.

(b) CONFORMING AMENDMENT RELATING TO DETERMINATION OF STANDARDIZED AMOUNT.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended—

(1) by striking ''1999 or'' and inserting ''1999,''; and

(2) by inserting '', or the Prescription Drug and Medicare Improvement Act of 2003'' after ''2000''.

SA 1005. Mr. SANTORUM submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle C of title II, add the following:

SEC. ___. EXTENSION OF PHASE-IN OF NEW RISK ADJUSTER.

(a) UNDER MEDICARE+CHOICE.—Section 1853(a)(3)(C)(ii) is amended—

(1) in subclause (I), by striking ''2003'' and inserting ''2005'';

(2) in subclause (II), by striking ''2004'' and inserting ''2006'';

(3) in subclause (III), by striking ''2005'' and inserting ''2007'';

(4) in subclause (IV), by striking ''2006'' and inserting ''2008''; and

(5) in subclause (V), by striking ''2007'' and inserting ''2009''.

(b) UNDER MEDICAREADVANTAGE.—Section 1853(a)(3)(A) (42 U.S.C. 1395w–23(a)(3)(A)), as amended by section 203, is amended to read as follows:

''(A) APPLICATION OF METHODOLOGY.—

''(i) IN GENERAL.—The Secretary shall apply the comprehensive risk adjustment methodology described in subparagraph (B) to the applicable percentage of the amount of payments to plans under subsection (d)(4)(B).

''(ii) APPLICABLE PERCENTAGE DEFINED.—For purposes of clause (i), the term 'applicable percentage' means—

''(II) for 2006, 30 percent;

''(III) for 2007, 50 percent;

''(IV) for 2008, 75; and

''(V) for 2009 and each subsequent year, 100 percent.''.

(c) EFFECTIVE DATES.—The amendments made—

(1) by subsection (a) shall take effect on the date of enactment of this Act; and

(2) by subsection (b) shall apply to plan years beginning on or after January 1, 2006.

SA 1006. Mr. SANTORUM submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle C of title II, add the following:

SEC. ___. REVISION OF REQUIREMENTS FOR REVIEW OF MARKETING MATERIALS.

(a) UNDER MEDICARE+CHOICE AND MEDICAREADVANTAGE.—Section 1851(h) (42 U.S.C. 1395w–21(h)) is amended—

(1) in paragraph (1)(A), by striking ''45 days (or 10 days in the case described in paragraph (5))'' and inserting ''30 days (or 10 days in the case described in paragraph (5) or if the Medicare+Choice organization has submitted to the Secretary requested corrections following review of the submitted material)''; and

(2) by striking paragraph (2) and inserting the following new paragraph:

''(2) REVIEW.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the standards established under section 1856 shall include guidelines for the review of any material or form submitted and under such guidelines the Secretary shall disapprove (or later require the correction of) such material or form if the material or form is materially inaccurate or misleading or otherwise makes a material misrepresentation.

''(B) EXCEPTION.—Notwithstanding any other requirements of section 1856(h), the Secretary shall establish policies that permit, under appropriate circumstances, the distribution of marketing materials by a Medicare+Choice organization prior to review.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of enactment of this Act and shall apply to section 1851(h) of the Social Security Act (42 U.S.C. 1395w–21(h)) as in effect on such date and as amended by section 201.

SA 1007. Mr. SANTORUM submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle C of title II, add the following:

SEC. ___. AUTHORIZATION OF DIRECT PAYMENTS TO PROVIDERS FOR SERVICES PROVIDED TO MEDICARE ADVANTAGE ENROLLEES PARTICIPATING IN MEDICARE COVERED CLINICAL TRIALS.

(a) UNDER MEDICARE+CHOICE AND MEDICAREADVANTAGE.—

(1) IN GENERAL.—Section 1852(a)(1)(A) (42 U.S.C. 1395w–22(a)(1)(A)) is amended by inserting ''and items and services that are covered under part A or B as a result of a national coverage determination for qualifying clinical trials'' after ''hospice care''.

(2) PAYMENT.—Section 1853 (42 U.S.C. 1395w–23) is amended by adding at the end the following new subsection:

''(j) SPECIAL RULE FOR COVERED COSTS ASSOCIATED WITH QUALIFYING CLINICAL TRIALS.—

''(1) INFORMATION.—The Medicare+Choice organization shall inform each individual enrolled under this part with a Medicare+Choice plan offered by the organization that the medicare program covers certain costs associated with the participation by a medicare beneficiary in a qualifying clinical trial.

''(2) PAYMENT.—If an individual who is enrolled with a Medicare+Choice organization under this part participates in a qualifying clinical trial, payment for the medicare covered costs associated with that clinical trial shall be made by the Secretary directly to the provider or supplier furnishing such services.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of enactment of this Act and shall apply to sections 1852 and 1853 of the Social Security Act (42 U.S.C. 1395w–22 and 1395w–23) as in effect on such date and as amended by sections 202 and 203.

SA 1008. Mr. SANTORUM submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 134, between lines 9 and 10, insert the following:

''(d) ZERO PREMIUM STOP-LOSS PROTECTION AND ACCESS TO NEGOTIATED PRICES FOR CERTAIN ELIGIBLE BENEFICIARIES ENROLLED IN THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM AFTER 2013.—

''(1) IN GENERAL.—Notwithstanding the preceding provisions of this part, the following rules shall apply with respect to an applicable eligible beneficiary enrolled in a Medicare Prescription Drug plan or under a contract under section 1860D–13(e):

''(A) NO PREMIUM.—Notwithstanding sections 1860D–13(e)(2) and 1860D–17, the monthly beneficiary obligation for enrollment in the Medicare Prescription Drug plan or under a contract under section 1860D–13(e) shall be zero.

''(B) BENEFICIARY RECEIVES ACCESS TO NEGOTIATED PRICES AND STOP-LOSS PROTECTION FOR NO ADDITIONAL PREMIUM.—Notwithstanding section 1860D–6, qualified prescription drug coverage shall include coverage of covered drugs that meets the following requirements:

''(i) The coverage has cost-sharing (for costs up to the annual out-of-pocket limit under subsection (c)(4) of such section) that is equal to 100 percent.

''(ii) The coverage provides the limitation on out-of-pocket expenditures under such subsection (c)(4).

''(ii) The coverage provides access to negotiated prices under subsection (e) of such section during the entire year.

''(C) APPLICATION OF LOW-INCOME SUBSIDIES.—Notwithstanding section 1860D–19, the Administrator shall not apply the following provisions of subsection (a) of such section:

''(i) Subparagraphs (A), (B), (C), and (D) of paragraph (1).

''(ii) Subparagraphs (A), (B), (C), and (D) of paragraph (2).

''(iii) Clauses (i), (ii), (iii), and (iv) of paragraph (3)(A).

''(2) APPLICABLE ELIGIBLE BENEFICIARY.—For purposes of this subsection, the term 'applicable eligible beneficiary' means an eligible beneficiary who—

''(A) is enrolled under this part; and

''(B) became an eligible beneficiary for the first time on or after January 1, 2014.

''(3) PROCEDURES.—The Administrator shall establish procedures to carry out this subsection. Under such procedures, the Administrator may waive or modify any of the preceding provisions of this part to the extent necessary to carry out this subsection.

''(4) NO EFFECT ON BENEFICIARIES ENROLLED IN A MEDICAREADVANTAGE PLAN THAT PROVIDES QUALIFIED PRESCRIPTION DRUG COVERAGE.—This subsection shall have no effect on eligible beneficiaries enrolled in this part and under a MedicareAdvantage plan that provides qualified prescription drug coverage.''.

SA 1009. Mr. INOUYE (for himself and Mr. AKAKA) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, add the following:

SEC. ___. 100 PERCENT FMAP FOR MEDICAL ASSISTANCE PROVIDED TO A NATIVE HAWAIIAN THROUGH A FEDERALLY-QUALIFIED HEALTH CENTER OR A NATIVE HAWAIIAN HEALTH CARE SYSTEM UNDER THE MEDICAID PROGRAM.

(a) MEDICAID.—Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended, in the third sentence, by inserting '', and with respect to medical assistance provided to a Native Hawaiian (as defined in section 12 of the Native Hawaiian Health Care Improvement Act) through a Federally-qualified health center or a Native Hawaiian health care system (as so defined) whether directly, by referral, or under contract or other arrangement between a Federally-qualified health center or a Native Hawaiian health care system and another health care provider'' before the period.

(b) EFFECTIVE DATE.—The amendment made by this section applies to medical assistance provided on or after the date of enactment of this Act.

SA 1010. Mr. SUNUNU submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end of subtitle B of title IV, add the following:

SEC. ___. IMPROVEMENT OF OUTPATIENT VISION SERVICES UNDER PART B.

(a) COVERAGE UNDER PART B.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended—

(1) in subparagraph (U), by striking ''and'' after the semicolon at the end;

(2) in subparagraph (V)(iii), by adding ''and'' after the semicolon at the end; and

(3) by adding at the end the following new subparagraph:

''(W) vision rehabilitation services (as defined in subsection (ww)(1));''.

(b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Vision Rehabilitation Services; Vision Rehabilitation Professional

''(ww)(1)(A) The term 'vision rehabilitation services' means rehabilitative services (as determined by the Secretary in regulations) furnished—

''(i) to an individual diagnosed with a vision impairment (as defined in paragraph (6));

''(ii) pursuant to a plan of care established by a qualified physician (as defined in subparagraph (C)) or by a qualified occupational therapist that is periodically reviewed by a qualified physician;

''(iii) in an appropriate setting (including the home of the individual receiving such services if specified in the plan of care); and

''(iv) by any of the following individuals:

''(I) A qualified physician.

''(II) A qualified occupational therapist.

''(III) A vision rehabilitation professional (as defined in paragraph (2)) while under the general supervision (as defined in subparagraph (D)) of a qualified physician.

''(B) In the case of vision rehabilitation services furnished by a vision rehabilitation professional, the plan of care may only be established and reviewed by a qualified physician.

''(C) The term 'qualified physician' means—

''(i) a physician (as defined in subsection (r)(1)) who is an ophthalmologist; or

''(ii) a physician (as defined in subsection (r)(4) (relating to a doctor of optometry)).

''(D) The term 'general supervision' means, with respect to a vision rehabilitation professional, overall direction and control of that professional by the qualified physician who established the plan of care for the individual, but the presence of the qualified physician is not required during the furnishing of vision rehabilitation services by that professional to the individual.

''(2) The term 'vision rehabilitation professional' means any of the following individuals:

''(A) An orientation and mobility specialist (as defined in paragraph (3)).

''(B) A rehabilitation teacher (as defined in paragraph (4)).

''(C) A low vision therapist (as defined in paragraph (5)).

''(3) The term 'orientation and mobility specialist' means an individual who—

''(A) if a State requires licensure or certification of orientation and mobility specialists, is licensed or certified by that State as an orientation and mobility specialist;

''(B)(i) holds a baccalaureate or higher degree from an accredited college or university in the United States (or an equivalent foreign degree) with a concentration in orientation and mobility; and

''(ii) has successfully completed 350 hours of clinical practicum under the supervision of an orientation and mobility specialist and has furnished not less than 9 months of supervised full-time orientation and mobility services;

''(C) has successfully completed the national examination in orientation and mobility administered by the Academy for Certification of Vision Rehabilitation and Education Professionals; and

''(D) meets such other criteria as the Secretary establishes.

''(4) The term 'rehabilitation teacher' means an individual who—

''(A) if a State requires licensure or certification of rehabilitation teachers, is licensed or certified by the State as a rehabilitation teacher;

''(B)(i) holds a baccalaureate or higher degree from an accredited college or university in the United States (or an equivalent foreign degree) with a concentration in rehabilitation teaching, or holds such a degree in a health field; and

''(ii) has successfully completed 350 hours of clinical practicum under the supervision of a rehabilitation teacher and has furnished not less than 9 months of supervised full-time rehabilitation teaching services;

''(C) has successfully completed the national examination in rehabilitation teaching administered by the Academy for Certification of Vision Rehabilitation and Education Professionals; and

''(D) meets such other criteria as the Secretary establishes.

''(5) The term 'low vision therapist' means an individual who—

''(A) if a State requires licensure or certification of low vision therapists, is licensed or certified by the State as a low vision therapist;

''(B)(i) holds a baccalaureate or higher degree from an accredited college or university in the United States (or an equivalent foreign degree) with a concentration in low vision therapy, or holds such a degree in a health field; and

''(ii) has successfully completed 350 hours of clinical practicum under the supervision of a physician, and has furnished not less than 9 months of supervised full-time low vision therapy services;

''(C) has successfully completed the national examination in low vision therapy administered by the Academy for Certification of Vision Rehabilitation and Education Professionals; and

''(D) meets such other criteria as the Secretary establishes.

''(6) The term 'vision impairment' means vision loss that constitutes a significant limitation of visual capability resulting from disease, trauma, or a congenital or degenerative condition that cannot be corrected by conventional means, including refractive correction, medication, or surgery, and that is manifested by 1 or more of the following:

''(A) Best corrected visual acuity of less than 20/60, or significant central field defect.

''(B) Significant peripheral field defect including homonymous or heteronymous bilateral visual field defect or generalized contraction or constriction of field.

''(C) Reduced peak contrast sensitivity in conjunction with a condition described in subparagraph (A) or (B).

''(D) Such other diagnoses, indications, or other manifestations as the Secretary may determine to be appropriate.''.

(c) PAYMENT UNDER PART B.—

(1) PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) (42 U.S.C. 1395w–4(j)(3)) is amended by inserting ''(2)(W),'' after ''(2)(S),''.

(2) CARVE OUT FROM HOSPITAL OUTPATIENT DEPARTMENT PROSPECTIVE PAYMENT SYSTEM.—Section 1833(t)(1)(B)(iv) (42 U.S.C. 1395l(t)(1)(B)(iv)) is amended by inserting ''vision rehabilitation services (as defined in section 1861(ww)(1)) or'' after ''does not include''.

(3) CLARIFICATION OF BILLING REQUIREMENTS.—The first sentence of section 1842(b)(6) of such Act (42 U.S.C. 1395u(b)(6)) is amended—

(A) by striking ''and'' before ''(G)''; and

(B) by inserting before the period the following: '', and (H) in the case of vision rehabilitation services (as defined in section 1861(ww)(1)) furnished by a vision rehabilitation professional (as defined in section 1861(ww)(2)) while under the general supervision (as defined in section 1861(ww)(1)(D)) of a qualified physician (as defined in section 1861(ww)(1)(C)), payment shall be made to (i) the qualified physician or (ii) the facility (such as a rehabilitation agency, a clinic, or other facility) through which such services are furnished under the plan of care if there is a contractual arrangement between the vision rehabilitation professional and the facility under which the facility submits the bill for such services''.

(d) PLAN OF CARE.—Section 1835(a)(2) (42 U.S.C. 1395n(a)(2)) is amended—

(1) in subparagraph (E), by striking ''and'' after the semicolon at the end;

(2) in subparagraph (F), by striking the period at the end and inserting ''; and''; and

(3) by inserting after subparagraph (F) the following new subparagraph:

''(G) in the case of vision rehabilitation services, (i) such services are or were required because the individual needed vision rehabilitation services, (ii) an individualized, written plan for furnishing such services has been established (I) by a qualified physician (as defined in section 1861(ww)(1)(C)), (II) by a qualified occupational therapist, or (III) in the case of such services furnished by a vision rehabilitation professional, by a qualified physician, (iii) the plan is periodically reviewed by the qualified physician, and (iv) such services are or were furnished while the individual is or was under the care of the qualified physician.''.

(e) RELATIONSHIP TO REHABILITATION ACT OF 1973.—The provision of vision rehabilitation services under the medicare program under title XVIII (42 U.S.C. 1395 et seq.) shall not be taken into account for any purpose under the Rehabilitation Act of 1973 (29 U.S.C. 701 et seq.).

(f) EFFECTIVE DATE.—

(1) INTERIM, FINAL REGULATIONS.—The Secretary shall publish a rule under this section in the Federal Register by not later than 180 days after the date of enactment of this Act to carry out the provisions of this section. Such rule shall be effective and final immediately on an interim basis, but is subject to change and revision after public notice and opportunity for a period for public comment of not less than 60 days.

(2) CONSULTATION.—The Secretary shall consult with the National Vision Rehabilitation Cooperative, the Association for Education and Rehabilitation of the Blind and Visually Impaired, the Academy for Certification of Vision Rehabilitation and Education Professionals, the American Academy of Ophthalmology, the American Occupational Therapy Association, the American Optometric Association, and such other qualified professional and consumer organizations as the Secretary determines appropriate in promulgating regulations to carry out this section.

SA 1011. Mr. SESSIONS proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

Strike section 605 and insert the following:

SEC. 605. SENSE OF THE SENATE REGARDING HEALTH INSURANCE COVERAGE OF LEGAL IMMIGRANTS UNDER MEDICAID AND SCHIP.

FINDINGS.—The Senate makes the following findings:

(1) In 1996, in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2105)(commonly referred to as the ''welfare

reform Act''), Congress deliberately limited the Federal public benefits available to legal immigrants.

(2) The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 allows a State the option of electing to offer permanent resident legal aliens that have been living in the United States for at least 5 years the same benefits that their State citizens receive under the temporary assistance for needy families program (commonly referred to as ''TANF'') and the medicaid program.

(3) As of the date of enactment of this Act, 22 States have elected to give the permanent resident legal aliens who reside in their States the same TANF and medicaid benefits as the States provide to the citizens of their States.

(4) This Act, the Prescription Drug and Medicare Improvement Act of 2003, is not a welfare or medicaid reform bill, but rather is a package of improvements for the medicare program that is designed to provide greater access to health care for America's seniors.

(5) The section heading for 605 of this Act as reported out of the Committee on Finance, was titled ''Assistance with Coverage of Legal Immigrants under the medicaid program and SCHIP,'' and, as reported, related directly to the provision of benefits under the medicaid and State children's health insurance programs, not to benefits provided under the medicare program.

(6) The reported version of section 605 would have directly overturned the reforms made in the 1996 welfare reform Act.

(7) The reported version of section 605 would have greatly expanded the number of individuals who could receive benefits under medicaid and SCHIP.

(8) No hearings have been held in the Committee on Finance of the Senate concerning why the 5-year residency requirement for legal aliens to obtain a Federal public benefit established in the welfare reform Act needs to be overturned or why the reported version of section 605 should be included in a medicare reform package.

(9) Congress must reauthorize the temporary assistance for needy families program later this year and should hold hearings regarding whether the 5-year residency requirement for legal aliens to obtain a Federal public benefit should be overturned as part of the reauthorization of that program.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that the Committee on Finance of the Senate should hold hearings in connection with the reauthorization of the temporary assistance for needy families program, or in connection with reform of the medicaid program, regarding whether the 5-year residency requirement for legal aliens to obtain a Federal public benefit that was established in the 1996 welfare reform Act should be overturned for purposes of the medicaid and State children's health insurance programs.

SA 1012. Mr. HAGEL (for himself and Mr. ENSIGN) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

Title I is amended by adding at the end the following:

Subtitle E—Voluntary Medicare Prescription Drug Discount and Security Program

SEC. 141. VOLUNTARY MEDICARE PRESCRIPTION DRUG DISCOUNT AND SECURITY PROGRAM.

(a) ESTABLISHMENT OF PROGRAM.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by section 101, is amended—

(1) by redesignating part E as part F; and

(2) by inserting after part D the following new part:

''PART E—VOLUNTARY MEDICARE PRESCRIPTION DRUG DISCOUNT AND SECURITY PROGRAM

''DEFINITIONS

''SEC. 1860E. In this part:

''(1) COVERED DRUG.—

''(A) IN GENERAL.—Except as provided in this paragraph, the term 'covered drug' means—

''(i) a drug that may be dispensed only upon a prescription and that is described in subparagraph (A)(i) or (A)(ii) of section 1927(k)(2); or

''(ii) a biological product described in clauses (i) through (iii) of subparagraph (B) of such section or insulin described in subparagraph (C) of such section

and such term includes a vaccine licensed under section 351 of the Public Health Service Act and any use of a covered drug for a medically accepted indication (as defined in section 1927(k)(6)).

''(B) EXCLUSIONS.—

''(i) IN GENERAL.—Such term does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2), other than subparagraph (E) thereof (relating to smoking cessation agents), or under section 1927(d)(3).

''(ii) AVOIDANCE OF DUPLICATE COVERAGE.—A drug prescribed for an individual that would otherwise be a covered drug under this part shall not be so considered if payment for such drug is available under part A or B for an individual entitled to benefits under part A and enrolled under part B.

''(C) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an individual that would otherwise be a covered drug under this part shall not be so considered under a plan if the plan excludes the drug under a formulary and such exclusion is not successfully appealed under section 1860E–4(a)(4)(B).

''(D) APPLICATION OF GENERAL EXCLUSION PROVISIONS.—A prescription drug discount card plan or MedicareAdvantage plan may exclude from qualified prescription drug coverage any covered drug—

''(i) for which payment would not be made if section 1862(a) applied to part E; or

''(ii) which are not prescribed in accordance with the plan or this part.

Such exclusions are determinations subject to reconsideration and appeal pursuant to section 1860E–4(a)(4).

''(2) ELIGIBLE BENEFICIARY.—The term 'eligible beneficiary' means an individual who is—

''(A) eligible for benefits under part A or enrolled under part B; and

''(B) not eligible for prescription drug coverage under a State plan under the medicaid program under title XIX.

''(3) ELIGIBLE ENTITY.—The term 'eligible entity' means any—

''(A) pharmaceutical benefit management company;

''(B) wholesale pharmacy delivery system;

''(C) retail pharmacy delivery system;

''(D) insurer (including any issuer of a medicare supplemental policy under section 1882);

''(E) MedicareAdvantage organization;

''(F) State (in conjunction with a pharmaceutical benefit management company);

''(G) employer-sponsored plan;

''(H) other entity that the Secretary determines to be appropriate to provide benefits under this part; or

''(I) combination of the entities described in subparagraphs (A) through (H).

''(4) POVERTY LINE.—The term 'poverty line' means the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

''(5) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services.

''ESTABLISHMENT OF PROGRAM

''SEC. 1860E–1. (a) PROVISION OF BENEFIT.—The Secretary shall establish a Medicare Prescription Drug Discount and Security Program under which the Secretary endorses prescription drug card plans offered by eligible entities in which eligible beneficiaries may voluntarily enroll and receive benefits under this part. Notwithstanding any other provision of this title, an eligible beneficiary may elect to enroll in the program under this part in lieu of the program established under part D. An eligible beneficiary may not be enrolled under both this part and part D.

''(b) ENDORSEMENT OF PRESCRIPTION DRUG DISCOUNT CARD PLANS.—

''(1) IN GENERAL.—The Secretary shall endorse a prescription drug card plan offered by an eligible entity with a contract under this part if the eligible entity meets the requirements of this part with respect to that plan.

''(2) NATIONAL PLANS.—In addition to other types of plans, the Secretary may endorse national prescription drug plans under paragraph (1).

''(c) VOLUNTARY NATURE OF PROGRAM.—Nothing in this part shall be construed as requiring an eligible beneficiary to enroll in the program under this part.

''(d) FINANCING.—The costs of providing benefits under this part shall be payable from the Federal Supplementary Medical Insurance Trust Fund established under section 1841.

''ENROLLMENT

''SEC. 1860E–2. (a) ENROLLMENT UNDER PART E.—

''(1) ESTABLISHMENT OF PROCESS.—

''(A) IN GENERAL.—The Secretary shall establish a process through which an eligible beneficiary (including an eligible beneficiary enrolled in a MedicareAdvantage plan offered by a MedicareAdvantage organization) may make an election to enroll under this part. Except as otherwise provided in this subsection, such process shall be similar to the process for enrollment under part B under section 1837.

''(B) REQUIREMENT OF ENROLLMENT.—An eligible beneficiary must enroll under this part in order to be eligible to receive the benefits under this part.

''(2) ENROLLMENT PERIODS.—

''(A) IN GENERAL.—Except as provided in this paragraph, an eligible beneficiary may not enroll in the program under this part during any period after the beneficiary's initial enrollment period under part B (as determined under section 1837).

''(B) SPECIAL ENROLLMENT PERIOD.—In the case of eligible beneficiaries that have recently lost eligibility for prescription drug coverage under a State plan under the medicaid program under title XIX, the Secretary shall establish a special enrollment period in

which such beneficiaries may enroll under this part.

''(C) OPEN ENROLLMENT PERIOD IN 2005 FOR CURRENT BENEFICIARIES.—The Secretary shall establish a period, which shall begin on the date on which the Secretary first begins to accept elections for enrollment under this part, during which any eligible beneficiary may—

''(i) enroll under this part; or

''(ii) enroll or reenroll under this part after having previously declined or terminated such enrollment.

''(3) PERIOD OF COVERAGE.—

''(A) IN GENERAL.—Except as provided in subparagraph (B) and subject to subparagraph (C), an eligible beneficiary's coverage under the program under this part shall be effective for the period provided under section 1838, as if that section applied to the program under this part.

''(B) ENROLLMENT DURING OPEN AND SPECIAL ENROLLMENT.—Subject to subparagraph (C), an eligible beneficiary who enrolls under the program under this part under subparagraph (B) or (C) of paragraph (2) shall be entitled to the benefits under this part beginning on the first day of the month following the month in which such enrollment occurs.

''(4) PART E COVERAGE TERMINATED BY TERMINATION OF COVERAGE UNDER PARTS A AND B OR ELIGIBILITY FOR MEDICAL ASSISTANCE.—

''(A) IN GENERAL.—In addition to the causes of termination specified in section 1838, the Secretary shall terminate an individual's coverage under this part if the individual is—

''(i) no longer enrolled in part A or B; or

''(ii) eligible for prescription drug coverage under a State plan under the medicaid program under title XIX.

''(B) EFFECTIVE DATE.—The termination described in subparagraph (A) shall be effective on the effective date of—

''(i) the termination of coverage under part A or (if later) under part B; or

''(ii) the coverage under title XIX.

''(b) ENROLLMENT WITH ELIGIBLE ENTITY.—

''(1) PROCESS.—The Secretary shall establish a process through which an eligible beneficiary who is enrolled under this part shall make an annual election to enroll in a prescription drug card plan offered by an eligible entity that has been awarded a contract under this part and serves the geographic area in which the beneficiary resides.

''(2) ELECTION PERIODS.—

''(A) IN GENERAL.—Except as provided in this paragraph, the election periods under this subsection shall be the same as the coverage election periods under the MedicareAdvantage program under section 1851(e), including—

''(i) annual coordinated election periods; and

''(ii) special election periods.

In applying the last sentence of section 1851(e)(4) (relating to discontinuance of a MedicareAdvantage election during the first year of eligibility) under this subparagraph, in the case of an election described in such section in which the individual had elected or is provided qualified prescription drug coverage at the time of such first enrollment, the individual shall be permitted to enroll in a prescription drug card plan under this part at the time of the election of coverage under the original fee-for-service plan.

''(B) INITIAL ELECTION PERIODS.—

''(i) INDIVIDUALS CURRENTLY COVERED.—In the case of an individual who is entitled to benefits under part A or enrolled under part B as of November 1, 2005, there shall be an initial election period of 6 months beginning on that date.

''(ii) INDIVIDUAL COVERED IN FUTURE.—In the case of an individual who is first entitled to benefits under part A or enrolled under part B after such date, there shall be an initial election period which is the same as the initial enrollment period under section 1837(d).

''(C) ADDITIONAL SPECIAL ELECTION PERIODS.—The Administrator shall establish special election periods—

''(i) in cases of individuals who have and involuntarily lose prescription drug coverage described in paragraph (3);

''(ii) in cases described in section 1837(h) (relating to errors in enrollment), in the same manner as such section applies to part B; and

''(iii) in the case of an individual who meets such exceptional conditions (including conditions provided under section 1851(e)(4)(D)) as the Secretary may provide.

''(D) ENROLLMENT WITH ONE PLAN ONLY.—The rules established under subparagraph (B) shall ensure that an eligible beneficiary may only enroll in 1 prescription drug card plan offered by an eligible entity per year.

''(3) MEDICAREADVANTAGE ENROLLEES.—An eligible beneficiary who is enrolled under this part and enrolled in a MedicareAdvantage plan offered by a MedicareAdvantage organization must enroll in a prescription drug discount card plan offered by an eligible entity in order to receive benefits under this part. The beneficiary may elect to receive such benefits through the MedicareAdvantage organization in which the beneficiary is enrolled if the organization has been awarded a contract under this part.

''(4) CONTINUOUS PRESCRIPTION DRUG COVERAGE.—An individual is considered for purposes of this part to be maintaining continuous prescription drug coverage on and after the date the individual first qualifies to elect prescription drug coverage under this part if the individual establishes that as of such date the individual is covered under any of the following prescription drug coverage and before the date that is the last day of the 63-day period that begins on the date of termination of the particular prescription drug coverage involved (regardless of whether the individual subsequently obtains any of the following prescription drug coverage):

''(A) COVERAGE UNDER PRESCRIPTION DRUG CARD PLAN OR MEDICAREADVANTAGE PLAN.—Prescription drug coverage under a prescription drug card plan under this part or under a MedicareAdvantage plan.

''(B) MEDICAID PRESCRIPTION DRUG COVERAGE.—Prescription drug coverage under a medicaid plan under title XIX, including through the Program of All-inclusive Care for the Elderly (PACE) under section 1934, through a social health maintenance organization (referred to in section 4104(c) of the Balanced Budget Act of 1997), or through a MedicareAdvantage project that demonstrates the application of capitation payment rates for frail elderly medicare beneficiaries through the use of a interdisciplinary team and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved.

''(C) PRESCRIPTION DRUG COVERAGE UNDER GROUP HEALTH PLAN.—Any prescription drug coverage under a group health plan, including a health benefits plan under the Federal Employees Health Benefit Plan under chapter 89 of title 5, United States Code, and a qualified retiree prescription drug plan (as defined by the Secretary), but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a prescription drug card plan under this part.

''(D) PRESCRIPTION DRUG COVERAGE UNDER CERTAIN MEDIGAP POLICIES.—Coverage under a medicare supplemental policy under section 1882 that provides benefits for prescription drugs (whether or not such coverage conforms to the standards for packages of benefits under section 1882(p)(1)) and if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a prescription drug card plan under this part.

''(E) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—Coverage of prescription drugs under a State pharmaceutical assistance program, but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a prescription drug card plan under this part.

''(F) VETERANS' COVERAGE OF PRESCRIPTION DRUGS.—Coverage of prescription drugs for veterans under chapter 17 of title 38, United States Code, but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a prescription drug card plan under this part.

For purposes of carrying out this paragraph, the certifications of the type described in sections 2701(e) of the Public Health Service Act and in section 9801(e) of the Internal Revenue Code of 1986 shall also include a statement for the period of coverage of whether the individual involved had prescription drug coverage described in this paragraph.

''(5) COMPETITION.—Each eligible entity with a contract under this part shall compete for the enrollment of beneficiaries in a prescription drug card plan offered by the entity on the basis of discounts, formularies, pharmacy networks, and other services provided for under the contract.

''PROVIDING ENROLLMENT AND COVERAGE INFORMATION TO BENEFICIARIES

''SEC. 1860E–3. (a) ACTIVITIES.—The Secretary shall provide for activities under this part to broadly disseminate information to eligible beneficiaries (and prospective eligible beneficiaries) regarding enrollment under this part and the prescription drug card plans offered by eligible entities with a contract under this part.

''(b) SPECIAL RULE FOR FIRST ENROLLMENT UNDER THE PROGRAM.—To the extent practicable, the activities described in subsection (a) shall ensure that eligible beneficiaries are provided with such information at least 60 days prior to the first enrollment period described in section 1860E–2(c).

''ENROLLEE PROTECTIONS

''SEC. 1860E–4. (a) REQUIREMENTS FOR ALL ELIGIBLE ENTITIES.—Each eligible entity shall meet the following requirements:

''(1) GUARANTEED ISSUANCE AND NONDISCRIMINATION.—

''(A) GUARANTEED ISSUANCE.—

''(i) IN GENERAL.—An eligible beneficiary who is eligible to enroll in a prescription drug card plan offered by an eligible entity under section 1860E–2(b) for prescription drug coverage under this part at a time during which elections are accepted under this part with respect to the coverage shall not be denied enrollment based on any health status-related factor (described in section 2702(a)(1) of the Public Health Service Act) or any other factor.

''(ii) MEDICAREADVANTAGE LIMITATIONS PERMITTED.—The provisions of paragraphs (2) and (3) (other than subparagraph (C)(i), relating to default enrollment) of section 1851(g) (relating to priority and limitation on termination of election) shall apply to eligible entities under this subsection.

''(B) NONDISCRIMINATION.—An eligible entity offering prescription drug coverage under this part shall not establish a service area in a manner that would discriminate based on health or economic status of potential enrollees.

''(2) DISCLOSURE OF INFORMATION.—

''(A) INFORMATION.—

''(i) GENERAL INFORMATION.—Each eligible entity with a contract under this part to provide a prescription drug card plan shall disclose, in a clear, accurate, and standardized form to each eligible beneficiary enrolled in a prescription drug discount card program offered by such entity under this part at the time of enrollment and at least annually thereafter, the information described in section 1852(c)(1) relating to such prescription drug coverage.

''(ii) SPECIFIC INFORMATION.—In addition to the information described in clause (i), each eligible entity with a contract under this part shall disclose the following:

''(I) How enrollees will have access to covered drugs, including access to such drugs through pharmacy networks.

''(II) How any formulary used by the eligible entity functions.

''(III) Information on grievance and appeals procedures.

''(IV) Information on enrollment fees and prices charged to the enrollee for covered drugs.

''(V) Any other information that the Secretary determines is necessary to promote informed choices by eligible beneficiaries among eligible entities.

''(B) DISCLOSURE UPON REQUEST OF GENERAL COVERAGE, UTILIZATION, AND GRIEVANCE INFORMATION.—Upon request of an eligible beneficiary, the eligible entity shall provide the information described in paragraph (3) to such beneficiary.

''(C) RESPONSE TO BENEFICIARY QUESTIONS.—Each eligible entity offering a prescription drug discount card plan under this part shall have a mechanism for providing specific information to enrollees upon request. The entity shall make available, through an Internet website and, upon request, in writing, information on specific changes in its formulary.

''(3) GRIEVANCE MECHANISM, COVERAGE DETERMINATIONS, AND RECONSIDERATIONS.—

''(A) IN GENERAL.—With respect to the benefit under this part, each eligible entity offering a prescription drug discount card plan shall provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the eligible entity provides covered benefits) and enrollees with prescription drug card plans of the eligible entity under this part in accordance with section 1852(f).

''(B) APPLICATION OF COVERAGE DETERMINATION AND RECONSIDERATION PROVISIONS.—Each eligible entity shall meet the requirements of paragraphs (1) through (3) of section 1852(g) with respect to covered benefits under the prescription drug card plan it offers under this part in the same manner as such requirements apply to a MedicareAdvantage organization with respect to benefits it offers under a MedicareAdvantage plan under part C.

''(C) REQUEST FOR REVIEW OF TIERED FORMULARY DETERMINATIONS.—In the case of a prescription drug card plan offered by an eligible entity that provides for tiered cost-sharing for drugs included within a formulary and provides lower cost-sharing for preferred drugs included within the formulary, an individual who is enrolled in the plan may request coverage of a nonpreferred drug under the terms applicable for preferred drugs if the prescribing physician determines that the preferred drug for treatment of the same condition is not as effective for the individual or has adverse effects for the individual.

''(4) APPEALS.—

''(A) IN GENERAL.—Subject to subparagraph (B), each eligible entity offering a prescription drug card plan shall meet the requirements of paragraphs (4) and (5) of section 1852(g) with respect to drugs not included on any formulary in the same manner as such requirements apply to a MedicareAdvantage organization with respect to benefits it offers under a MedicareAdvantage plan under part C.

''(B) FORMULARY DETERMINATIONS.—An individual who is enrolled in a prescription drug card plan offered by an eligible entity may appeal to obtain coverage under this part for a covered drug that is not on a formulary of the eligible entity if the prescribing physician determines that the formulary drug for treatment of the same condition is not as effective for the individual or has adverse effects for the individual.

''(5) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—Each eligible entity offering a prescription drug discount card plan shall meet the requirements of the Health Insurance Portability and Accountability Act of 1996.

''(b) ELIGIBLE ENTITIES OFFERING A DISCOUNT CARD PROGRAM.—If an eligible entity offers a discount card program under this part, in addition to the requirements under subsection (a), the entity shall meet the following requirements:

''(1) ACCESS TO COVERED BENEFITS.—

''(A) ASSURING PHARMACY ACCESS.—

''(i) IN GENERAL.—The eligible entity offering the prescription drug discount card plan shall secure the participation in its network of a sufficient number of pharmacies that dispense (other than by mail order) drugs directly to patients to ensure convenient access (as determined by the Secretary and including adequate emergency access) for enrolled beneficiaries, in accordance with standards established under section 1860E–4(a)(3) that ensure such convenient access.

''(ii) USE OF POINT-OF-SERVICE SYSTEM.—Each eligible entity offering a prescription drug discount card plan shall establish an optional point-of-service method of operation under which—

''(I) the plan provides access to any or all pharmacies that are not participating pharmacies in its network; and

''(II) discounts under the plan may not be available.

The additional copayments so charged shall not be counted as out-of-pocket expenses for purposes of section 1860E–6(b).

''(B) USE OF STANDARDIZED TECHNOLOGY.—

''(i) IN GENERAL.—Each eligible entity offering a prescription drug discount card plan shall issue (and reissue, as appropriate) such a card (or other technology) that may be used by an enrolled beneficiary to assure access to negotiated prices under section 1860E–6(a) for the purchase of prescription drugs for which coverage is not otherwise provided under the prescription drug discount card plan.

''(ii) STANDARDS.—The Secretary shall provide for the development of national standards relating to a standardized format for the card or other technology referred to in clause (i). Such standards shall be compatible with standards established under part C of title XI.

''(C) REQUIREMENTS ON DEVELOPMENT AND APPLICATION OF FORMULARIES.—If an eligible entity that offers a prescription drug discount card plan uses a formulary, the following requirements must be met:

''(i) PHARMACY AND THERAPEUTIC (P&T) COMMITTEE.—The eligible entity must establish a pharmacy and therapeutic committee that develops and reviews the formulary. Such committee shall include at least 1 physician and at least 1 pharmacist both with expertise in the care of elderly or disabled persons and a majority of its members shall consist of individuals who are a physician or a practicing pharmacist (or both).

''(ii) FORMULARY DEVELOPMENT.—In developing and reviewing the formulary, the committee shall base clinical decisions on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, such as randomized clinical trials, pharmacoeconomic studies, outcomes research data, and such other information as the committee determines to be appropriate.

''(iii) INCLUSION OF DRUGS IN ALL THERAPEUTIC CATEGORIES.—The formulary must include drugs within each therapeutic category and class of covered drugs (although not necessarily for all drugs within such categories and classes).

''(iv) PROVIDER EDUCATION.—The committee shall establish policies and procedures to educate and inform health care providers concerning the formulary.

''(v) NOTICE BEFORE REMOVING DRUGS FROM FORMULARY.—Any removal of a drug from a formulary shall take effect only after appropriate notice is made available to beneficiaries and physicians.

''(vi) GRIEVANCES AND APPEALS RELATING TO APPLICATION OF FORMULARIES.—For provisions relating to grievances and appeals of coverage, see paragraphs (3) and (4) of section 1860E–4(a).

''(2) COST AND UTILIZATION MANAGEMENT; QUALITY ASSURANCE; MEDICATION THERAPY MANAGEMENT PROGRAM.—

''(A) IN GENERAL.—Each eligible entity offering a prescription drug discount card plan shall have in place with respect to covered drugs—

''(i) an effective cost and drug utilization management program, including medically appropriate incentives to use generic drugs and therapeutic interchange, when appropriate;

''(ii) quality assurance measures and systems to reduce medical errors and adverse drug interactions, including a medication therapy management program described in subparagraph (B); and

''(iii) a program to control fraud, abuse, and waste.

Nothing in this section shall be construed as impairing an eligible entity from applying cost management tools (including differential payments) under all methods of operation.

''(B) MEDICATION THERAPY MANAGEMENT PROGRAM.—

''(i) IN GENERAL.—A medication therapy management program described in this paragraph is a program of drug therapy management and medication administration that is designed to ensure, with respect to beneficiaries with chronic diseases (such as diabetes, asthma, hypertension, and congestive heart failure) or multiple prescriptions, that covered drugs under the prescription drug discount card plan are appropriately used to achieve therapeutic goals and reduce the risk of adverse events, including adverse drug interactions.

''(ii) ELEMENTS.—Such program may include—

''(I) enhanced beneficiary understanding of such appropriate use through beneficiary education, counseling, and other appropriate means;

''(II) increased beneficiary adherence with prescription medication regimens through medication refill reminders, special packaging, and other appropriate means; and

''(III) detection of patterns of overuse and underuse of prescription drugs.

''(iii) DEVELOPMENT OF PROGRAM IN COOPERATION WITH LICENSED PHARMACISTS.—The program shall be developed in cooperation with licensed pharmacists and physicians.

''(iv) CONSIDERATIONS IN PHARMACY FEES.—Each eligible entity offering a prescription drug discount card plan shall take into account, in establishing fees for pharmacists and others providing services under the medication therapy management program, the resources and time used in implementing the program.

''(C) TREATMENT OF ACCREDITATION.—Section 1852(e)(4) (relating to treatment of accreditation) shall apply to prescription drug discount card plans under this part with respect to the following requirements, in the same manner as they apply to MedicareAdvantage plans under part C with respect to the requirements described in a clause of section 1852(e)(4)(B):

''(i) Paragraph (1) (including quality assurance), including any medication therapy management program under paragraph (2).

''(ii) Subsection (c)(1) (relating to access to covered benefits).

''(iii) Subsection (g) (relating to confidentiality and accuracy of enrollee records).

''(D) PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR EQUIVALENT DRUGS.—Each eligible entity offering a prescription drug discount card plan shall provide that each pharmacy or other dispenser that arranges for the dispensing of a covered drug shall inform the beneficiary at the time of purchase of the drug of any differential between the price of the prescribed drug to the enrollee and the price of the lowest cost drug covered under the plan that is therapeutically equivalent and bioequivalent.

''ANNUAL ENROLLMENT FEE

''SEC. 1860E–5. (a) AMOUNT.—

''(1) IN GENERAL.—Except as provided in subsection (c), enrollment under the program under this part is conditioned upon payment of an annual enrollment fee of $25.

''(2) ANNUAL PERCENTAGE INCREASE.—

''(A) IN GENERAL.—In the case of any calendar year beginning after 2006, the dollar amount in paragraph (1) shall be increased by an amount equal to—

''(i) such dollar amount; multiplied by

''(ii) the inflation adjustment.

''(B) INFLATION ADJUSTMENT.—For purposes of subparagraph (A)(ii), the inflation adjustment for any calendar year is the percentage (if any) by which—

''(i) the average per capita aggregate expenditures for covered drugs in the United States for medicare beneficiaries, as determined by the Secretary for the 12-month period ending in July of the previous year; exceeds

''(ii) such aggregate expenditures for the 12-month period ending with July 2005.

''(C) ROUNDING.—If any increase determined under clause (ii) is not a multiple of $1, such increase shall be rounded to the nearest multiple of $1.

''(b) COLLECTION OF ANNUAL ENROLLMENT FEE.—

''(1) IN GENERAL.—Unless the eligible beneficiary makes an election under paragraph (2), the annual enrollment fee described in subsection (a) shall be collected and credited to the Federal Supplementary Medical Insurance Trust Fund in the same manner as the monthly premium determined under section 1839 is collected and credited to such Trust Fund under section 1840.

''(2) DIRECT PAYMENT.—An eligible beneficiary may elect to pay the annual enrollment fee directly or in any other manner approved by the Secretary. The Secretary shall establish procedures for making such an election.

''(c) WAIVER.—The Secretary shall waive the enrollment fee described in subsection (a) in the case of an eligible beneficiary whose income is below 200 percent of the poverty line.

''BENEFITS UNDER THE PROGRAM

''SEC. 1860E–6. (a) ACCESS TO NEGOTIATED PRICES.—

''(1) NEGOTIATED PRICES.—

''(A) IN GENERAL.—Subject to subparagraph (B), each prescription drug card plan offering a discount card program by an eligible entity with a contract under this part shall provide each eligible beneficiary enrolled in such plan with access to negotiated prices (including applicable discounts) for such prescription drugs as the eligible entity determines appropriate. Such discounts may include discounts for nonformulary drugs. If such a beneficiary becomes eligible for the catastrophic benefit under subsection (b), the negotiated prices (including applicable discounts) shall continue to be available to the beneficiary for those prescription drugs for which payment may not be made under section 1860E–8(b). For purposes of this subparagraph, the term 'prescription drugs' is not limited to covered drugs, but does not include any over-the-counter drug that is not a covered drug.

''(B) LIMITATIONS.—

''(i) FORMULARY RESTRICTIONS.—Insofar as an eligible entity with a contract under this part uses a formulary, the negotiated prices (including applicable discounts) for nonformulary drugs may differ.

''(ii) AVOIDANCE OF DUPLICATE COVERAGE.—The negotiated prices (including applicable discounts) for prescription drugs shall not be available for any drug prescribed for an eligible beneficiary if payment for the drug is available under part A or B (but such negotiated prices shall be available if payment under part A or B is not available because the beneficiary has not met the deductible or has exhausted benefits under part A or B).

''(2) DISCOUNT CARD.—The Secretary shall develop a uniform standard card format to be issued by each eligible entity offering a prescription drug discount card plan that shall be used by an enrolled beneficiary to ensure the access of such beneficiary to negotiated prices under paragraph (1).

''(3) ENSURING DISCOUNTS IN ALL AREAS.—The Secretary shall develop procedures that ensure that each eligible beneficiary that resides in an area where no prescription drug discount card plans are available is provided with access to negotiated prices for prescription drugs (including applicable discounts).

''(b) CATASTROPHIC BENEFIT.—

''(1) TEN PERCENT COST-SHARING.—Subject to any formulary used by the prescription drug discount card program in which the eligible beneficiary is enrolled, the catastrophic benefit shall provide benefits with cost-sharing that is equal to 10 percent of the negotiated price (taking into account any applicable discounts) of each drug dispensed to such beneficiary after the beneficiary has incurred costs (as described in paragraph (3)) for covered drugs in a year equal to the applicable annual out-of-pocket limit specified in paragraph (2).

''(2) ANNUAL OUT-OF-POCKET LIMITS.—For purposes of this part, the annual out-of-pocket limits specified in this paragraph are as follows:

''(A) BENEFICIARIES WITH ANNUAL INCOMES BELOW 200 PERCENT OF THE POVERTY LINE.—In the case of an eligible beneficiary whose income (as determined under section 1860E–9) is below 200 percent of the poverty line, the annual out-of-pocket limit is equal to $1,500.

''(B) BENEFICIARIES WITH ANNUAL INCOMES BETWEEN 200 AND 400 PERCENT OF THE POVERTY LINE.—In the case of an eligible beneficiary whose income (as so determined) equals or exceeds 200 percent, but does not exceed 400 percent, of the poverty line, the annual out-of-pocket limit is equal to $3,500.

''(C) BENEFICIARIES WITH ANNUAL INCOMES BETWEEN 400 AND 600 PERCENT OF THE POVERTY LINE.—In the case of an eligible beneficiary whose income (as so determined) equals or exceeds 400 percent, but does not exceed 600 percent, of the poverty line, the annual out-of-pocket limit is equal to $5,500.

''(D) BENEFICIARIES WITH ANNUAL INCOMES THAT EXCEED 600 PERCENT OF THE POVERTY LINE.—In the case of an eligible beneficiary whose income (as so determined) equals or exceeds 600 percent of the poverty line, the annual out-of-pocket limit is an amount equal to 20 percent of that beneficiary's income for that year (rounded to the nearest multiple of $1).

''(3) APPLICATION.—In applying paragraph (2), incurred costs shall only include those expenses for covered drugs that are incurred by the eligible beneficiary using a card approved by the Secretary under this part that are paid by that beneficiary and for which the beneficiary is not reimbursed (through insurance or otherwise) by another person.

''(4) ANNUAL PERCENTAGE INCREASE.—

''(A) IN GENERAL.—In the case of any calendar year after 2005, the dollar amounts in subparagraphs (A), (B), and (C) of paragraph (2) shall be increased by an amount equal to—

''(i) such dollar amount; multiplied by

''(ii) the inflation adjustment determined under section 1860E–5(a)(2)(B) for such calendar year.

''(B) ROUNDING.—If any increase determined under subparagraph (A) is not a multiple of $1, such increase shall be rounded to the nearest multiple of $1.

''(5) ELIGIBLE ENTITY NOT AT FINANCIAL RISK FOR CATASTROPHIC BENEFIT.—

''(A) IN GENERAL.—The Secretary, and not the eligible entity, shall be at financial risk for the provision of the catastrophic benefit under this subsection.

''(B) PROVISIONS RELATING TO PAYMENTS TO ELIGIBLE ENTITIES.—For provisions relating to payments to eligible entities for administering the catastrophic benefit under this subsection, see section 1860E–8.

''(6) ENSURING CATASTROPHIC BENEFIT IN ALL AREAS.—The Secretary shall develop procedures for the provision of the catastrophic benefit under this subsection to each eligible beneficiary that resides in an area where there are no prescription drug discount card plans offered that have been awarded a contract under this part.

''REQUIREMENTS FOR ENTITIES TO PROVIDE PRESCRIPTION DRUG COVERAGE

''SEC. 1860E–7. (a) ESTABLISHMENT OF BIDDING PROCESS.—The Secretary shall establish a process under which the Secretary accepts bids from eligible entities and awards contracts to the entities to provide the benefits under this part to eligible beneficiaries in an area.

''(b) SUBMISSION OF BIDS.—Each eligible entity desiring to enter into a contract under this part shall submit a bid to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may require.

''(c) ADMINISTRATIVE FEE BID.—

''(1) SUBMISSION.—For the bid described in subsection (b), each entity shall submit to the Secretary information regarding administration of the discount card and catastrophic benefit under this part.

''(2) BID SUBMISSION REQUIREMENTS.—

''(A) ADMINISTRATIVE FEE BID SUBMISSION.—In submitting bids, the entities shall include separate costs for administering the discount card component, if applicable, and the catastrophic benefit. The entity shall submit the administrative fee bid in a form and manner specified by the Secretary, and shall include a statement of projected enrollment and a separate statement of the projected administrative costs for at least the following functions:

''(i) Enrollment, including income eligibility determination.

''(ii) Claims processing.

''(iii) Quality assurance, including drug utilization review.

''(iv) Beneficiary and pharmacy customer service.

''(v) Coordination of benefits.

''(vi) Fraud and abuse prevention.

''(B) NEGOTIATED ADMINISTRATIVE FEE BID AMOUNTS.—The Secretary has the authority to negotiate regarding the bid amounts submitted. The Secretary may reject a bid if the Secretary determines it is not supported by the administrative cost information provided in the bid as specified in subparagraph (A).

''(C) PAYMENT TO PLANS BASED ON ADMINISTRATIVE FEE BID AMOUNTS.—The Secretary shall use the bid amounts to calculate a benchmark amount consisting of the enrollment-weighted average of all bids for each function and each class of entity. The class of entity is either a regional or national entity, or such other classes as the Secretary may determine to be appropriate. The functions are the discount card and catastrophic components. If an eligible entity's combined bid for both functions is above the combined benchmark within the entity's class for the functions, the eligible entity shall collect additional necessary revenue through 1 or both of the following:

''(i) Additional fees charged to the beneficiary, not to exceed $25 annually.

''(ii) Use of rebate amounts from drug manufacturers to defray administrative costs.

''(d) AWARDING OF CONTRACTS.—

''(1) IN GENERAL.—The Secretary shall, consistent with the requirements of this part and the goal of containing medicare program costs, award at least 2 contracts in each area, unless only 1 bidding entity meets the terms and conditions specified by the Secretary under paragraph (2).

''(2) TERMS AND CONDITIONS.—The Secretary shall not award a contract to an eligible entity under this section unless the Secretary finds that the eligible entity is in compliance with such terms and conditions as the Secretary shall specify.

''(3) REQUIREMENTS FOR ELIGIBLE ENTITIES PROVIDING DISCOUNT CARD PROGRAM.—Except as provided in subsection (e), in determining which of the eligible entities that submitted bids that meet the terms and conditions specified by the Secretary under paragraph (2) to award a contract, the Secretary shall consider whether the bid submitted by the entity meets at least the following requirements:

''(A) LEVEL OF SAVINGS TO MEDICARE BENEFICIARIES.—The program passes on to medicare beneficiaries who enroll in the program discounts on prescription drugs, including discounts negotiated with manufacturers.

''(B) PROHIBITION ON APPLICATION ONLY TO MAIL ORDER.—The program applies to drugs that are available other than solely through mail order and provides convenient access to retail pharmacies.

''(C) LEVEL OF BENEFICIARY SERVICES.—The program provides pharmaceutical support services, such as education and services to prevent adverse drug interactions.

''(D) ADEQUACY OF INFORMATION.—The program makes available to medicare beneficiaries through the Internet and otherwise information, including information on enrollment fees, prices charged to beneficiaries, and services offered under the program, that the Secretary identifies as being necessary to provide for informed choice by beneficiaries among endorsed programs.

''(E) EXTENT OF DEMONSTRATED EXPERIENCE.—The entity operating the program has demonstrated experience and expertise in operating such a program or a similar program.

''(F) EXTENT OF QUALITY ASSURANCE.—The entity has in place adequate procedures for assuring quality service under the program.

''(G) OPERATION OF ASSISTANCE PROGRAM.—The entity meets such requirements relating to solvency, compliance with financial reporting requirements, audit compliance, and contractual guarantees as specified by the Secretary.

''(H) PRIVACY COMPLIANCE.—The entity implements policies and procedures to safeguard the use and disclosure of program beneficiaries' individually identifiable health information in a manner consistent with the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

''(I) ADDITIONAL BENEFICIARY PROTECTIONS.—The program meets such additional requirements as the Secretary identifies to protect and promote the interest of medicare beneficiaries, including requirements that ensure that beneficiaries are not charged more than the lower of the negotiated retail price or the usual and customary price.

The prices negotiated by a prescription drug discount card program endorsed under this section shall (notwithstanding any other provision of law) not be taken into account for the purposes of establishing the best price under section 1927(c)(1)(C).

''(4) BENEFICIARY ACCESS TO SAVINGS AND REBATES.—The Secretary shall require eligible entities offering a discount card program to pass on savings and rebates negotiated with manufacturers to eligible beneficiaries enrolled with the entity.

''(5) NEGOTIATED AGREEMENTS WITH EMPLOYER-SPONSORED PLANS.—Notwithstanding any other provision of this part, the Secretary may negotiate agreements with employer-sponsored plans under which eligible beneficiaries are provided with a benefit for prescription drug coverage that is more generous than the benefit that would otherwise have been available under this part if such an agreement results in cost savings to the Federal Government.

''(e) REQUIREMENTS FOR OTHER ELIGIBLE ENTITIES.—An eligible entity that is licensed under State law to provide the health insurance benefits under this section shall be required to meet the requirements of subsection (d)(3). If an eligible entity offers a national plan, such entity shall not be required to meet the requirements of subsection (d)(3), but shall meet the requirements of Employee Retirement Income Security Act of 1974 that apply with respect to such plan.

''PAYMENTS TO ELIGIBLE ENTITIES FOR ADMINISTERING THE CATASTROPHIC BENEFIT

''SEC. 1860E–8. (a) IN GENERAL.—The Secretary may establish procedures for making payments to an eligible entity under a contract entered into under this part for—

''(1) the costs of providing covered drugs to beneficiaries eligible for the benefit under this part in accordance with subsection (b) minus the amount of any cost-sharing collected by the eligible entity under section 1860E–6(b); and

''(2) costs incurred by the entity in administering the catastrophic benefit in accordance with section 1860E–7.

''(b) PAYMENT FOR COVERED DRUGS.—

''(1) IN GENERAL.—Except as provided in subsection (c) and subject to paragraph (2), the Secretary may only pay an eligible entity for covered drugs furnished by the eligible entity to an eligible beneficiary enrolled with such entity under this part that is eligible for the catastrophic benefit under section 1860E–6(b).

''(2) LIMITATIONS.—

''(A) FORMULARY RESTRICTIONS.—Insofar as an eligible entity with a contract under this part uses a formulary, the Secretary may not make any payment for a covered drug that is not included in such formulary, except to the extent provided under section 1860E–4(a)(4)(B).

''(B) NEGOTIATED PRICES.—The Secretary may not pay an amount for a covered drug furnished to an eligible beneficiary that exceeds the negotiated price (including applicable discounts) that the beneficiary would have been responsible for under section 1860E–6(a) or the price negotiated for insurance coverage under the MedicareAdvantage program under part C, a medicare supplemental policy, employer-sponsored coverage, or a State plan.

''(C) COST-SHARING LIMITATIONS.—An eligible entity may not charge an individual enrolled with such entity who is eligible for the catastrophic benefit under this part any copayment, tiered copayment, coinsurance, or other cost-sharing that exceeds 10 percent of the cost of the drug that is dispensed to the individual.

''(3) PAYMENT IN COMPETITIVE AREAS.—In a geographic area in which 2 or more eligible entities offer a plan under this part, the Secretary may negotiate an agreement with the entity to reimburse the entity for costs incurred in providing the benefit under this part on a capitated basis.

''(c) SECONDARY PAYER PROVISIONS.—The provisions of section 1862(b) shall apply to the benefits provided under this part.

''DETERMINATION OF INCOME LEVELS

''SEC. 1860E–9. (a) DETERMINATION OF INCOME LEVELS.—

''(1) IN GENERAL.—The Secretary shall establish procedures under which each eligible entity awarded a contract under this part determines the income levels of eligible beneficiaries enrolled in a prescription drug card plan offered by that entity at least annually for purposes of sections 1860E–5(c) and 1860E–6(b).

''(2) PROCEDURES.—The procedures established under paragraph (1) shall require each eligible beneficiary to submit such information as the eligible entity requires to make the determination described in paragraph (1).

''(b) ENFORCEMENT OF INCOME DETERMINATIONS.—The Secretary shall—

''(1) establish procedures that ensure that eligible beneficiaries comply with sections 1860E–5(c) and 1860E–6(b); and

''(2) require, if the Secretary determines that payments were made under this part to which an eligible beneficiary was not entitled, the repayment of any excess payments with interest and a penalty.

''(c) QUALITY CONTROL SYSTEM.—

''(1) ESTABLISHMENT.—The Secretary shall establish a quality control system to monitor income determinations made by eligible entities under this section and to produce appropriate and comprehensive measures of error rates.

''(2) PERIODIC AUDITS.—The Inspector General of the Department of Health and Human Services shall conduct periodic audits to ensure that the system established under paragraph (1) is functioning appropriately.

''APPROPRIATIONS

''SEC. 1860E–10. There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Federal Supplementary Medical Insurance Trust Fund established under section 1841, an amount equal to the amount by which the benefits and administrative costs of providing the benefits under this part exceed the enrollment fees collected under section 1860E–5.

''MEDICARE COMPETITION AND PRESCRIPTION DRUG ADVISORY BOARD

''SEC. 1860E–11. (a) ESTABLISHMENT OF BOARD.—There is established a Medicare Prescription Drug Advisory Board (in this section referred to as the 'Board').

''(b) ADVICE ON POLICIES; REPORTS.—

''(1) ADVICE ON POLICIES.—The Board shall advise the Secretary on policies relating to the Voluntary Medicare Prescription Drug Discount and Security Program under this part.

''(2) REPORTS.—

''(A) IN GENERAL.—With respect to matters of the administration of the program under this part, the Board shall submit to Congress and to the Secretary such reports as the Board determines appropriate. Each such report may contain such recommendations as the Board determines appropriate for legislative or administrative changes to improve the administration of the program under this part. Each such report shall be published in the Federal Register.

''(B) MAINTAINING INDEPENDENCE OF BOARD.—The Board shall directly submit to Congress reports required under subparagraph (A). No officer or agency of the United States may require the Board to submit to any officer or agency of the United States for approval, comments, or review, prior to the submission to Congress of such reports.

''(c) STRUCTURE AND MEMBERSHIP OF THE BOARD.—

''(1) MEMBERSHIP.—The Board shall be composed of 7 members who shall be appointed as follows:

''(A) PRESIDENTIAL APPOINTMENTS.—

''(i) IN GENERAL.—Three members shall be appointed by the President, by and with the advice and consent of the Senate.

''(ii) LIMITATION.—Not more than 2 such members may be from the same political party.

''(B) SENATORIAL APPOINTMENTS.—Two members (each member from a different political party) shall be appointed by the President pro tempore of the Senate with the advice of the Chairman and the Ranking Minority Member of the Committee on Finance of the Senate.

''(C) CONGRESSIONAL APPOINTMENTS.—Two members (each member from a different political party) shall be appointed by the Speaker of the House of Representatives, with the advice of the Chairman and the Ranking Minority Member of the Committee on Ways and Means of the House of Representatives.

''(2) QUALIFICATIONS.—The members shall be chosen on the basis of their integrity, impartiality, and good judgment, and shall be individuals who are, by reason of their education, experience, and attainments, exceptionally qualified to perform the duties of members of the Board.

''(3) COMPOSITION.—Of the members appointed under paragraph (1)—

''(A) at least 1 shall represent the pharmaceutical industry;

''(B) at least 1 shall represent physicians;

''(C) at least 1 shall represent medicare beneficiaries;

''(D) at least 1 shall represent practicing pharmacists; and

''(E) at least 1 shall represent eligible entities.

''(d) TERMS OF APPOINTMENT.—

''(1) IN GENERAL.—Subject to paragraph (2), each member of the Board shall serve for a term of 6 years.

''(2) CONTINUANCE IN OFFICE AND STAGGERED TERMS.—

''(A) CONTINUANCE IN OFFICE.—A member appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

''(B) STAGGERED TERMS.—The terms of service of the members initially appointed under this section shall begin on January 1, 2006, and expire as follows:

''(i) PRESIDENTIAL APPOINTMENTS.—The terms of service of the members initially appointed by the President shall expire as designated by the President at the time of nomination, 1 each at the end of—

''(I) 2 years;

''(II) 4 years; and

''(III) 6 years.

''(ii) SENATORIAL APPOINTMENTS.—The terms of service of members initially appointed by the President pro tempore of the Senate shall expire as designated by the President pro tempore of the Senate at the time of nomination, 1 each at the end of—

''(I) 3 years; and

''(II) 6 years.

''(iii) CONGRESSIONAL APPOINTMENTS.—The terms of service of members initially appointed by the Speaker of the House of Representatives shall expire as designated by the Speaker of the House of Representatives at the time of nomination, 1 each at the end of—

''(I) 4 years; and

''(II) 5 years.

''(C) REAPPOINTMENTS.—Any person appointed as a member of the Board may not serve for more than 8 years.

''(D) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Board shall be filled in the manner in which the original appointment was made.

''(e) CHAIRPERSON.—A member of the Board shall be designated by the President to serve as Chairperson for a term of 4 years or, if the remainder of such member's term is less than 4 years, for such remainder.

''(f) EXPENSES AND PER DIEM.—Members of the Board shall serve without compensation, except that, while serving on business of the Board away from their homes or regular places of business, members may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government employed intermittently.

''(g) MEETINGS.—

''(1) IN GENERAL.—The Board shall meet at the call of the Chairperson (in consultation with the other members of the Board) not less than 4 times each year to consider a specific agenda of issues, as determined by the Chairperson in consultation with the other members of the Board.

''(2) QUORUM.—Four members of the Board (not more than 3 of whom may be of the same political party) shall constitute a quorum for purposes of conducting business.

''(h) FEDERAL ADVISORY COMMITTEE ACT.—The Board shall be exempt from the provisions of the Federal Advisory Committee Act (5 U.S.C. App.).

''(i) PERSONNEL.—

''(1) STAFF DIRECTOR.—The Board shall, without regard to the provisions of title 5, United States Code, relating to the competitive service, appoint a Staff Director who shall be paid at a rate equivalent to a rate established for the Senior Executive Service under section 5382 of title 5, United States Code.

''(2) STAFF.—

''(A) IN GENERAL.—The Board may employ, without regard to chapter 31 of title 5, United States Code, such officers and employees as are necessary to administer the activities to be carried out by the Board.

''(B) FLEXIBILITY WITH RESPECT TO CIVIL SERVICE LAWS.—

''(i) IN GENERAL.—The staff of the Board shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and, subject to clause (ii), shall be paid without regard to the provisions of chapters 51 and 53 of such title (relating to classification and schedule pay rates).

''(ii) MAXIMUM RATE.—In no case may the rate of compensation determined under clause (i) exceed the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

''(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, out of the Federal Supplemental Medical Insurance Trust Fund established under section 1841, and the general fund of the Treasury, such sums as are necessary to carry out the purposes of this section.''.

(b) CONFORMING REFERENCES TO PREVIOUS PART E.—

(1) IN GENERAL.—Any reference in law (in effect before the date of enactment of this Act) to part E of title XVIII of the Social Security Act is deemed a reference to part F of such title (as in effect after such date).

(2) SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 6 months after the date of enactment of this section, the Secretary of Health and Human Services shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this section.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendment made by subsection (a) shall take effect on the date of enactment of this Act.

(2) IMPLEMENTATION.—Notwithstanding any provision of part E of title XVIII of the Social Security Act (as added by subsection (a)), the Secretary of Health and Human Services shall implement the Voluntary Medicare Prescription Drug Discount and Security Program established under such part in a manner such that—

(A) benefits under such part for eligible beneficiaries (as defined in section 1860E of such Act, as added by such subsection) with annual incomes below 200 percent of the poverty line (as defined in such section) are available to such beneficiaries not later than the date that is 6 months after the date of enactment of this Act; and

(B) benefits under such part for other eligible beneficiaries are available to such beneficiaries not later than the date that is 1 year after the date of enactment of this Act.

SEC. 102. ADMINISTRATION OF VOLUNTARY MEDICARE PRESCRIPTION DRUG DISCOUNT AND SECURITY PROGRAM.

(a) ESTABLISHMENT OF CENTER FOR MEDICARE PRESCRIPTION DRUGS.—There is established, within the Centers for Medicare & Medicaid Services of the Department of Health and Human Services, a Center for Medicare Prescription Drugs. Such Center shall be separate from the Center for Beneficiary Choices, the Center for Medicare Management, and the Center for Medicaid and State Operations.

(b) DUTIES.—It shall be the duty of the Center for Medicare Prescription Drugs to administer the Voluntary Medicare Prescription Drug Discount and Security Program established under part E of title XVIII of the Social Security Act (as added by section 101).

(c) DIRECTOR.—

(1) APPOINTMENT.—There shall be in the Center for Medicare Prescription Drugs a Director of Medicare Prescription Drugs, who shall be appointed by the President, by and with the advice and consent of the Senate.

(2) RESPONSIBILITIES.—The Director shall be responsible for the exercise of all powers and the discharge of all duties of the Center for Medicare Prescription Drugs and shall have authority and control over all personnel and activities thereof.

(d) PERSONNEL.—The Director of the Center for Medicare Prescription Drugs may appoint and terminate such personnel as may be necessary to enable the Center for Medicare Prescription Drugs to perform its duties.

SEC. 103. EXCLUSION OF PART E COSTS FROM DETERMINATION OF PART B MONTHLY PREMIUM.

Section 1839(g) of the Social Security Act (42 U.S.C. 1395r(g)) is amended—

(1) by striking ''attributable to the application of section'' and inserting ''attributable to—

''(1) the application of section'';

(2) by striking the period and inserting ''; and''; and

(3) by adding at the end the following new paragraph:

''(2) the Voluntary Medicare Prescription Drug Discount and Security Program under part E.''.

SEC. 104. MEDIGAP REVISIONS.

Section 1882 of the Social Security Act (42 U.S.C. 1395ss) is amended by adding at the end the following new subsection:

''(v) MODERNIZATION OF MEDICARE SUPPLEMENTAL POLICIES.—

''(1) PROMULGATION OF MODEL REGULATION.—

''(A) NAIC MODEL REGULATION.—If, within 9 months after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, the National Association of Insurance Commissioners (in this subsection referred to as the 'NAIC') changes the 1991 NAIC Model Regulation (described in subsection (p)) to revise the benefit package classified as 'J' under the standards established by subsection (p)(2) (including the benefit package classified as 'J' with a high deductible feature, as described in subsection (p)(11)) so that—

''(i) the coverage for prescription drugs available under such benefit package is replaced with coverage for prescription drugs that complements but does not duplicate the benefits for prescription drugs that beneficiaries are otherwise entitled to under this title;

''(ii) a uniform format is used in the policy with respect to such revised benefits; and

''(iii) such revised standards meet any additional requirements imposed by the Prescription Drug and Medicare Improvement Act of 2003;

subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policy holders on and after January 1, 2006, as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation as changed under this subparagraph (such changed regulation referred to in this section as the '2006 NAIC Model Regulation').

''(B) REGULATION BY THE SECRETARY.—If the NAIC does not make the changes in the 1991 NAIC Model Regulation within the 9-month period specified in subparagraph (A), the Secretary shall promulgate, not later than 9 months after the end of such period, a regulation and subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policy holders on and after January 1, 2006, as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation as changed by the Secretary under this subparagraph (such changed regulation referred to in this section as the '2006 Federal Regulation').

''(C) CONSULTATION WITH WORKING GROUP.—In promulgating standards under this paragraph, the NAIC or Secretary shall consult with a working group similar to the working group described in subsection (p)(1)(D).

''(D) MODIFICATION OF STANDARDS IF MEDICARE BENEFITS CHANGE.—If benefits under part E of this title are changed and the Secretary determines, in consultation with the NAIC, that changes in the 2006 NAIC Model Regulation or 2006 Federal Regulation are needed to reflect such changes, the preceding provisions of this paragraph shall apply to the modification of standards previously established in the same manner as they applied to the original establishment of such standards.

''(2) CONSTRUCTION OF BENEFITS IN OTHER MEDICARE SUPPLEMENTAL POLICIES.—Nothing in the benefit packages classified as 'A' through 'I' under the standards established by subsection (p)(2) (including the benefit package classified as 'F' with a high deductible feature, as described in subsection (p)(11)) shall be construed as providing coverage for benefits for which payment may be made under part E.

''(3) APPLICATION OF PROVISIONS AND CONFORMING REFERENCES.—

''(A) APPLICATION OF PROVISIONS.—The provisions of paragraphs (4) through (10) of subsection (p) shall apply under this section, except that—

''(i) any reference to the model regulation applicable under that subsection shall be deemed to be a reference to the applicable 2006 NAIC Model Regulation or 2006 Federal Regulation; and

''(ii) any reference to a date under such paragraphs of subsection (p) shall be deemed to be a reference to the appropriate date under this subsection.

''(B) OTHER REFERENCES.—Any reference to a provision of subsection (p) or a date applicable under such subsection shall also be considered to be a reference to the appropriate provision or date under this subsection.''.

SA 1013. Mr. BOND (for himself and Mr. ROBERTS) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. COMMITTEE ON DRUG COMPOUNDING.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services shall establish an Committee on Drug Compounding (referred to in this section as the ''Committee'') within the Food and Drug Administration on drug compounding to ensure that patients are receiving necessary, safe and accurate dosages of compounded drugs.

(b) MEMBERSHIP.—The membership of the Advisory Committee shall be appointed by the Secretary of Health and Human Services and shall include representatives of—

(1) the National Association of Boards of Pharmacy;

(2) pharmacy groups;

(3) physician groups;

(4) consumer and patient advocate groups;

(5) the United States Pharmacopoeia; and

(6) other individuals determined appropriate by the Secretary.

(c) REPORT AND RECOMMENDATIONS.—Not later than 1 year after the date of enactment of this Act, the Committee shall submit to the Secretary a report concerning the recommendations of the Committee to improve and protect patient safety.

(d) TERMINATION.—The Committee shall terminate on the date that is 1 year after the date of enactment of this Act.

SA 1014. Mr. BOND submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 483, line 7, strike ''and'' and insert '', pharmacy services, and''.

SA 1015. Mr. DODD submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, insert the following:

SEC. ___. STUDY ON MAKING PRESCRIPTION PHARMACEUTICAL INFORMATION ACCESSIBLE FOR BLIND AND VISUALLY-IMPAIRED INDIVIDUALS.

(a) STUDY.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall undertake a study of how to make prescription pharmaceutical information, including drug labels and usage instructions, accessible to blind and visually-impaired individuals.

(2) STUDY TO INCLUDE EXISTING AND EMERGING TECHNOLOGIES.—The study under paragraph (1) shall include a review of existing and emerging technologies, including assistive technology, that makes essential information on the content and prescribed use of pharmaceutical medicines available in a usable format for blind and visually-impaired individuals.

(b) REPORT.—

(1) IN GENERAL.—Not later than 18 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit a report to Congress on the study required under subsection (a).

(2) CONTENTS OF REPORT.—The report required under subsection (a) shall include recommendations for the implementation of usable formats for making prescription pharmaceutical information available to blind and visually-impaired individuals and an estimate of the costs associated with the implementation of each format.

SA 1016. Mrs. CLINTON submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 654, after line 18 and before the amendment to the title, insert the following:

SEC. ___. INFORMATION TECHNOLOGY.

(a) IMPROVING CLINICAL PRACTICES.—

(1) TELEMEDICINE.—

(A) LICENSING.—Section 1834(m)(4)(C)(i) (42 U.S.C. 1395m(m)(4)(C)(i)) is amended—

(i) in subclause (II), by striking ''or'' at the end;

(ii) in subclause (III), by striking the period and inserting ''; or''; and

(iii) by adding at the end the following:

''(IV) in a State in which the respective State medical board has adopted a formal

policy regarding licensing or certification requirements for providers at distant sites who do not have a license to practice medicine at the originating site.''.

(B) EXPANDING ELIGIBILITY FOR REIMBURSEMENT.—Section 1834(m)(4)(C)(i)(I) (42 U.S.C. 1395m(m)(4)(C)(i)(I)) is amended by striking ''rural''.

(2) NIH TRIALS TO STUDY IMPACT OF TECHNOLOGY ON COST AND QUALITY OF HEALTH CARE.—

(A) FINDINGS.—Congress makes the following findings:

(i) An estimated 80,000 to 100,000 patients die every year from errors suffered during hospitalization.

(ii) Many of these errors could have been avoided with changes to the system of health care delivery.

(iii) These systemwide changes have the potential to decrease the cost of providing health care and to increase the quality of services provided.

(iv) These improvements in cost and quality can be as dramatic as improvements seen with new technology or pharmaceutical advances.

(v) Currently new medical devices and medications undergo rigorous randomized controlled clinical trials to document their effect on a patient's health.

(vi) These clinical trials form the basis for providers to practice evidence-based medicine and to change their practices to improve their patients' outcomes.

(vii) Similar controlled clinical studies of systems-based approaches to changing practice, if available, can help providers implement systems-based measures to improve outcomes.

(B) RESEARCH ON SYSTEMS-BASED APPROACHES TO CHANGING CLINICAL PRACTICE.—Part B of title IV of the Public Health Service Act (42 U.S.C. 284 et seq.) is amended by adding at the end the following:

''SEC. 409J. RESEARCH ON SYSTEMS-BASED APPROACHES TO CHANGING CLINICAL PRACTICE.

''(a) ESTABLISHMENT.—The Secretary shall establish within the Office of the Director of NIH a Medical Systems Safety Initiative (referred to in this section as the 'Initiative') to conduct and support research regarding systems-based approaches to improving and advancing medical care. The Initiative shall be headed by the Director of NIH (referred to in this section as the 'Director').

''(b) PURPOSE.—The purpose of the Initiative is to enable the Director of NIH—

''(1) to conduct and support basic and applied research (including both intramural and extramural research), research training, the dissemination of health information, and other programs with respect to systems research, user-centered design, and human factors engineering within the National Institutes of Health to realize the expanding opportunities for improving health outcomes through the analysis and redesign of medical systems;

''(2) to enhance collaborative efforts among the Institutes to conduct and support multidisciplinary research in the areas that the Director determines to be most promising; and

''(3) to encourage and support clinical studies to provide scientifically and statistically rigorous and meaningful information about the utility and effectiveness of various systems-based interventions.

''(c) APPROPRIATE SCIENTIFIC EXPERTISE AND COORDINATION WITH INSTITUTES AND FEDERAL AGENCIES.—The Director of NIH, after consultation with the Division of Research Grants, shall ensure that scientists with appropriate expertise in research on health systems, user-centered design, and human factors engineering are incorporated into the review, oversight, and management processes of all research projects and other activities funded by the Initiative. In carrying out this subsection, the Director, as necessary, may establish review groups with appropriate scientific expertise. The Director shall coordinate efforts with other Institutes and Federal agencies to ensure appropriate scientific input and management.

''(d) ENSURING HIGH QUALITY, RIGOROUS SCIENTIFIC REVIEW.—In order to ensure high quality, rigorous scientific review with respect to the Initiative, the Director of NIH shall conduct or support the following activities:

(1) Outcomes research and investigations.

(2) Epidemiological studies on the incidence and prevalence of various systems, practices, and processes within the health care system and their effect on health outcomes, both beneficial and harmful.

(3) Health services research.

(4) Basic science research.

(5) Clinical trials.

(6) Other appropriate research and investigational activities.''.

(b) IMPROVING AND PROMOTING ELECTRONIC MEDICAL RECORDS.—

(1) AUTHENTICATION STANDARDS.—The Director of the National Center for Vital and Health Statistics shall provide assistance to the Secretary of Health and Human Services in the development of authentication standards for health records. In developing such standards, the Secretary shall take into consideration the following:

(A) Recommendations for authentication technology and identification information standards that—

(i) provide for the reliable identification and retrieval of a patient's electronic medical data;

(ii) allow the patient to have detailed control over the access of individual components of his or her electronic medical record by being able to specify specific providers, each of whom will have access to limited portions of the electronic medical record;

(iii) minimize security risks, including the potential for—

(I) the patient to misrepresent his or her true identity;

(II) a health care provider to access data for which the patient has not consented to grant such access;

(III) a third party to access identification information; or

(IV) a third party to circumvent or exploit the authentication process in order to access electronic medical data without the consent of the patient;

(iv) allow for the timely and convenient creation of identification information at the time of contact between a patient and a provider, so as to minimize any disruption or delay in the provision of needed medical services to a patient who does not already have identification information; and

(v) maximize the probability of accurate identification, secure authentication, and rapid access to medical data even in situations where the patient—

(I) does not possess the identification information that is usually required for successful authentication, but wishes to grant consent to the provider to access necessary medical data;

(II) possesses the identification information but is not able to provide consent for the emergency access of medical data due to incapacitation; and

(III) is not able to provide identification information nor consent for emergency data access due to incapacitation.

(2) PERSONAL HEALTH RECORD.—

(A) FEDERAL HEALTH INFORMATION EXCHANGE STANDARDS INITIATIVE.—The Secretary of Health and Human Services, the Secretary of Defense, and the Secretary of Veterans' Affairs, in carrying out activities under the Federal e-Goverment Health Information Exchange Standards Initiative, shall jointly recommend standards for the implementation of personal health records that—

(i) includes the capability for patients to append to their electronic record information about—

(I) illnesses for which the patient did not seek professional medical care; and

(II) health information not related to a specific disease, episode, or illness; and

(ii) provides convenient access to the individual's full electronic medical record.

(B) MEDICAL TRANSLATION RESEARCH.—

(i) IN GENERAL.—The Director of the National Science Foundation shall award grants to public and nonprofit private entities for the conduct of basic research on innovative approaches to improve patients' understanding and comprehension of their electronic medical record. Research areas may include technology for the automated—

(I) translation of medical information to language more easily understandable by the patient;

(II) reorganization of the electronic medical record into a structure more useful to the patient; and

(III) integration of links to relevant information from other sources into the electronic medical record.

(ii) MERIT REVIEW; COMPETITION.—Grants shall be awarded under this subparagraph on a merit-reviewed competitive basis.

(iii) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the National Science Foundation to carry out this subparagraph—

(I) $5,000,000 for fiscal year 2004;

(II) $10,000,000 for fiscal year 2005; and

(III) $15,000,000 for fiscal year 2006 and each fiscal year thereafter.

(3) DEFINITIONS.—In this subsection:

(A) IDENTIFICATION INFORMATION.—The term ''identification information'' with respect to the medical records of a patient, means the data necessary to identify the patient.

(B) AUTHENTICATION.—The term ''authentication'' means the process of using the identification information to validate the patient's identification and gain access to his or her electronic medical data.

(c) IMPROVING INFORMATION TECHNOLOGY INFRASTRUCTURE IN THE BASIC LIFE SCIENCES.—Not later than 18 months after the date of enactment of this Act, the Director of the National Institute of General Medical Sciences shall submit to Congress a report on the activities of the Biomedical Information Science and Technology Initiative. Such report shall include—

(1) a description of current activities of the Biomedical Information Science and Technology Initiative Consortium;

(2) a summary of recently completed and ongoing grant programs; and

(3) recommendations for the further advancement of the Biomedical Information Science and Technology Initiative and bioinformatics and computational biology research in general.

(d) IMPROVING EDUCATION AND TRAINING.—Subpart 3 of part D of title IV of the Public Health Service Act (42 U.S.C. 286c et seq.) is amended by adding at the end the following:

''SEC. 478B. CERTIFICATION OF INFORMATION WEBSITES.

''(a) IN GENERAL.—The National Information Center on Health Services Research and Health Care Technology (in this section referred to as the 'Center') shall develop a voluntary certification program for health information websites on the Internet. As part of such program, websites shall be deemed to

be certified if they meet criteria that includes the following:

''(1) The website provides references to peer-reviewed rigorous scientific research for any conclusions or recommendations that it advocates.

''(2) The website is easy to navigate and comprehend by a general audience that does not have any specific medical training.

''(3) The website accommodates, to the maximum extent practicable, cultural, language, and literacy variation among its target audience.

''(b) LIMITATION.—In determining whether a website meets criteria for certification under the program under subsection (a), the Center may not consider—

''(1) the specific nature of the conclusions or recommendations of the website themselves, so long as they meet criteria for evidence as specified in subsection (a)(1); and

''(2) the person or organization responsible for the website.

''(c) PERIOD RECERTIFICATION.—In establishing the program under subsection (a), the Center shall develop a policy for the periodic expiration and renewal of certifications so as to ensure that websites are reviewed on a periodic basis for compliance with the criteria of certification.

''(d) SEAL.—The Center shall develop a seal or marker that can be used by a website that is certified under the program under subsection (a) to indicate to its audience that the website has obtained the Center's certification.

''(e) FEE.—The Center may assess an application fee for websites in order to cover the costs of evaluating the website.''.

SA 1017. Mr. ALLARD (for himself, Mr. FITZGERALD, and Ms. COLLINS) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, insert the following:

SEC. ___. TEMPORARY SUSPENSION OF OASIS REQUIREMENT FOR COLLECTION OF DATA ON NON-MEDICARE AND NON-MEDICAID PATIENTS.

(a) IN GENERAL.—During the period described in subsection (b), the Secretary may not require, under section 4602(e) of the Balanced Budget Act of 1997 or otherwise under OASIS, a home health agency to gather or submit information that relates to an individual who is not eligible for benefits under either title XVIII or title XIX of the Social Security Act (such information in this section referred to as ''non-medicare/medicaid OASIS information'').

(b) PERIOD OF SUSPENSION.—The period described in this subsection—

(1) begins on the date of the enactment of this Act; and

(2) ends on the last day of the 2nd month beginning after the date as of which the Secretary has published final regulations regarding the collection and use by the Centers for Medicare & Medicaid Services of non-medicare/medicaid OASIS information following the submission of the report required under subsection (c)

(c) REPORT.—

(1) STUDY.—The Secretary shall conduct a study on how non-medicare/medicaid OASIS information is and can be used by large home health agencies. Such study shall examine—

(A) whether there are unique benefits from the analysis of such information that cannot be derived from other information available to, or collected by, such agencies; and

(B) the value of collecting such information by small home health agencies compared to the administrative burden related to such collection.

In conducting the study the Secretary shall obtain recommendations from quality assessment experts in the use of such information and the necessity of small, as well as large, home health agencies collecting such information.

(2) REPORT.—The Secretary shall submit to Congress a report on the study conducted under paragraph (1) by not later than 18 months after the date of the enactment of this Act.

(d) CONSTRUCTION.—Nothing in this section shall be construed as preventing home health agencies from collecting non-medicare/medicaid OASIS information for their own use.

SA 1018. Mr. LIEBERMAN (for himself and Ms. COLLINS) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, insert the following:

SEC. ___. COLON CANCER SCREENING.

(a) SENSE OF CONGRESS.—It is the sense of Congress that—

(1) colorectal cancer screening tests (as defined in section 1861(pp) of the Social Security Act (42 U.S.C. 1395x(pp)) covered under the medicare program have been severely underutilized, with the Comptroller General of the United States reporting in 2000 that since coverage of such tests was implemented, the percentage of beneficiaries under the medicare program receiving either a screening or a diagnostic colonoscopy has increased by only 1 percent;

(2) the Centers for Medicare & Medicaid Services should encourage health care providers to use more effective screening and diagnostic health care technologies in the area of colorectal cancer screening;

(3) in recent years, the Centers for Medicare & Medicaid Services has subjected colorectal cancer screening tests to some of the largest reimbursement reductions under the medicare program;

(4) unlike other preventive screening tests covered under the medicare program, health care providers must consult with beneficiaries prior to furnishing a screening colonoscopy in order to—

(A) ascertain the medical and family history of the beneficiary; and

(B) inform the beneficiary of preparatory steps that must be taken prior to the procedure; and

(5) reimbursement under the medicare program is not currently available for the consultations described in paragraph (4) despite the fact that reimbursement is provided under such program for similar consultations prior to a diagnostic colonoscopy.

(b) INCREASE IN REIMBURSEMENT FOR COLORECTAL CANCER SCREENING AND DIAGNOSTIC TESTS.—

(1) IN GENERAL.—Section 1834(d) (42 U.S.C. 1395m(d)) is amended by adding at the end the following new paragraph:

''(4) ENHANCED PAYMENT FOR COLORECTAL CANCER SCREENING AND DIAGNOSTIC TESTS.—

''(A) FACILITY RATES.—Notwithstanding paragraphs (2)(A) and (3)(A), the Secretary shall establish national minimum payment amounts for CPT codes 45378, 45380, 45385 and HCPCS codes GO105 and GO121 for items and services furnished during the last 6 months of 2003 and in subsequent years which reflect a 30 percent increase above the relative value units in effect as the facility rates for such codes on June 30, 2003, with such revised payment level to apply to items and services performed in a facility setting.

''(B) ANNUAL ADJUSTMENTS.—In the case of items and services furnished on or after January 1, 2004, the payment rates described in subparagraph (A) shall, subject to the minimum payment amounts established in such subparagraph, be adjusted annually as provided in section 1848.''.

(2) EFFECT ON PART A PAYMENTS.—The Secretary shall not consider the national minimum payment described in section 1834(d)(4)(A) (42 U.S.C. 1395m(d)(4)(A)), as added by paragraph (1), when determining the hospital outpatient prospective payment system payment amounts under the relevant APC codes for colorectal cancer screening and diagnostic tests.

(3) EFFECTIVE DATE.—The amendment made by this subsection shall apply to items and services furnished on or after July 1, 2003.

(c) MEDICARE COVERAGE OF OFFICE VISIT OR CONSULTATION PRIOR TO A SCREENING COLONOSCOPY OR IN CONJUNCTION WITH A BENEFICIARY'S DECISION TO OBTAIN SUCH A SCREENING.—

(1) COVERAGE.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended—

(A) in subparagraph (U), by striking ''and'' at the end;

(B) in subparagraph (V), by inserting ''and'' at the end; and

(C) by adding at the end the following new subparagraph:

''(W) an outpatient office visit or consultation for the purpose of beneficiary education, assuring selection of the proper screening test, and securing information relating to the procedure and sedation of the beneficiary, prior to a colorectal cancer screening test consisting of a screening colonoscopy or in conjunction with the beneficiary's decision to obtain such a screening, regardless of whether such screening is medically indicated with respect to the beneficiary;''.

(2) PAYMENT.—

(A) IN GENERAL.—Section 1833(a)(1) (42 U.S.C. 1395*l*(a)(1)) is amended—

(i) by striking ''and'' before ''(U)''; and

(ii) by inserting before the semicolon at the end the following: '', and (V) with respect to an outpatient office visit or consultation under section 1861(s)(2)(W), the amounts paid shall be 80 percent of the lesser of the actual charge or the amount established under section 1848, except that no payment shall be made for such a visit or consultation if no payment would be made for a colorectal cancer screening test consisting of a screening colonoscopy for the individual furnished on the date of such visit or consultation because of the frequency limits described in section 1834(d)(3)(E)''.

(B) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) (42 U.S.C. 1395w–4(j)(3)) is amended by inserting ''(2)(W),'' after ''(2)(S),''.

(C) REQUIREMENT FOR ESTABLISHMENT OF PAYMENT AMOUNT UNDER PHYSICIAN FEE SCHEDULE.—Section 1834(d) (42 U.S.C. 1395m(d)), as amended by subsection (b), is amended by adding at the end the following new paragraph:

''(5) PAYMENT FOR OUTPATIENT OFFICE VISIT OR CONSULTATION PRIOR TO SCREENING COLONOSCOPY.—With respect to an outpatient office visit or consultation under section 1861(s)(2)(W), payment under section 1848 shall be consistent with the payment amounts for CPT codes 99203 and 99243.''.

(D) FREQUENCY LIMITATION.—Section 1862(a)(1) (42 U.S.C. 1395y(a)(1)) is amended—

(i) in subparagraph (H), by striking ''and'' at the end;

(ii) in subparagraph (I), by striking the semicolon at the end and inserting '', and''; and

(iii) by inserting after subparagraph (I) the following new subparagraph:

''(J) in the case of an outpatient office visit or consultation under section 1861(s)(2)(W), which is performed more frequently that is covered under section 1833(a)(1)(V);''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to items and services provided on or after July 1, 2003.

(d) WAIVER OF DEDUCTIBLE FOR COLORECTAL CANCER SCREENING TESTS.—

(1) IN GENERAL.—The first sentence of section 1833(b) (42 U.S.C. 1395*l*(b)) is amended—

(A) by striking ''and'' before ''(6)''; and

(B) by inserting before the period at the end the following: '', and (7) such deductible shall not apply with respect to colorectal cancer screening tests (as described in section 1861(pp)(1))''.

(2) CONFORMING AMENDMENTS.—Paragraphs (2)(C)(ii) and (3)(C)(ii) of section 1834(d) (42 U.S.C. 1395m(d)) are each amended—

(A) by striking ''DEDUCTIBLE AND'' in the heading; and

(B) in subclause (I), by striking ''deductible or'' each place it appears.

(3) EFFECTIVE DATE.—The amendment made by this subsection shall apply to items and services furnished on or after July 1, 2003.

SA 1019. Mr. CONRAD (for himself, Mrs. MURRAY, Mr. SMITH, Mrs. LINCOLN, and Mr. JEFFORDS) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes;

At the end of subtitle B of title IV, insert the following:

SEC. ___. MEDICARE COVERAGE OF SELF-INJECTED BIOLOGICALS.

(a) COVERAGE.—

(1) IN GENERAL.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended—

(A) in subparagraph (U), by striking ''and'' at the end;

(B) in subparagraph (V), by inserting ''and'' at the end; and

(C) by adding at the end the following new subparagraph:

''(W)(i) a self-injected biological (which is approved by the Food and Drug Administration) that is prescribed as a complete replacement for a drug or biological (including the same biological for which payment is made under this title when it is furnished incident to a physicians' service) that would otherwise be described in subparagraph (A) or (B) and that is furnished during 2004 or 2005; and

''(ii) a self-injected drug that is used to treat multiple sclerosis;''.

(2) CONFORMING AMENDMENT.—Subparagraphs (A) and (B) of section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) are each amended by inserting '', except for any drug or biological described in subparagraph (W),'' after ''which''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to drugs and biologicals furnished on or after January 1, 2004 and before January 1, 2006.

At the end of title VI, add the following:

SEC. ___. MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking ''promptly (as determined in accordance with regulations)''; and

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

''(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98–369).

(b) CLARIFYING AMENDMENTS TO CONDITIONAL PAYMENT PROVISIONS.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: ''An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.'';

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: ''A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.''; and

(B) in the final sentence, by striking ''on the date such notice or other information is received'' and inserting ''on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received''; and

(3) in subparagraph (B)(iii), as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: ''In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.''.

(c) CLERICAL AMENDMENTS.—Section 1862(b)(42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking ''such'' before ''paragraphs''.

SA 1020. Mr. CONRAD proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

Strike section 401 and insert the following:

SEC. 401. EQUALIZING URBAN AND RURAL STANDARDIZED PAYMENT AMOUNTS UNDER THE MEDICARE INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM.

(a) IN GENERAL.—Section 1886(d)(3)(A)(iv) (42 U.S.C. 1395ww(d)(3)(A)(iv)) is amended—

(1) by striking ''(iv) For discharges'' and inserting ''(iv)(I) Subject to subclause (II), for discharges''; and

(2) by adding at the end the following new subclause:

''(II) For discharges occurring in a fiscal year beginning with fiscal year 2004, the Secretary shall compute a standardized amount for hospitals located in any area within the United States and within each region equal to the standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for hospitals located in any area) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.''.

(b) CONFORMING AMENDMENTS.—

(1) COMPUTING DRG-SPECIFIC RATES.—Section 1886(d)(3)(D) (42 U.S.C. 1395ww(d)(3)(D)) is amended—

(A) in the heading, by striking ''IN DIFFERENT AREAS'';

(B) in the matter preceding clause (i), by striking '', each of'';

(C) in clause (i)—

(i) in the matter preceding subclause (I), by inserting ''for fiscal years before fiscal year 2004,'' before ''for hospitals''; and

(ii) in subclause (II), by striking ''and'' after the semicolon at the end;

(D) in clause (ii)—

(i) in the matter preceding subclause (I), by inserting ''for fiscal years before fiscal year 2004,'' before ''for hospitals''; and

(ii) in subclause (II), by striking the period at the end and inserting ''; and''; and

(E) by adding at the end the following new clause:

''(iii) for a fiscal year beginning after fiscal year 2003, for hospitals located in all areas, to the product of—

''(I) the applicable standardized amount (computed under subparagraph (A)), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C) for the fiscal year; and

''(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.''.

(2) TECHNICAL CONFORMING SUNSET.—Section 1886(d)(3) (42 U.S.C. 1395ww(d)(3)) is amended—

(A) in the matter preceding subparagraph (A), by inserting '', for fiscal years before fiscal year 1997,'' before ''a regional adjusted DRG prospective payment rate''; and

(B) in subparagraph (D), in the matter preceding clause (i), by inserting '', for fiscal years before fiscal year 1997,'' before ''a regional DRG prospective payment rate for each region,''.

At the end of title VI, add the following:

SEC. ___. MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking ''promptly (as determined in accordance with regulations)''; and

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

''(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98–369).

(b) CLARIFYING AMENDMENTS TO CONDITIONAL PAYMENT PROVISIONS.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: ''An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.'';

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: ''A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.''; and

(B) in the final sentence, by striking ''on the date such notice or other information is received'' and inserting ''on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received''; and

(3) in subparagraph (B)(iii), as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: ''In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.''.

(c) CLERICAL AMENDMENTS.—Section 1862(b)(42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking ''such'' before ''paragraphs''.

SA 1021. Mr. CONRAD1 proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end of subtitle A of title IV, add the following:

SEC. ___. GEOGRAPHIC RECLASSIFICATION OF CERTAIN HOSPITALS FOR PURPOSES OF REIMBURSEMENT UNDER THE MEDICARE PROGRAM.

(a) IN GENERAL.—Notwithstanding any other provision of law, effective for discharges occurring during fiscal year 2004 and each subsequent fiscal year, for purposes of making payments under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), hospitals located in the Bismarck, North Dakota Metropolitan Statistical Area are deemed to be located in the Fargo-Moorhead North Dakota-Minnesota Metropolitan Statistical Area.

(b) TREATMENT AS DECISION OF MEDICARE GEOGRAPHIC CLASSIFICATION REVIEW BOARD.—

(1) IN GENERAL.—Except as provided in paragraph (2), for purposes of section 1886(d) of the Social Security Act (42 U.S.C 1395ww(d)), any reclassification under subsection (a) shall be treated as a decision of the Medicare Geographic Classification Review Board under paragraph (10) of that section.

(2) NONAPPLICATION OF 3-YEAR APPLICATION PROVISION.—Section 1886(d)(10)(D)(v) of the Social Security Act (42 U.S.C. 1395ww(d)(10)(D)(v)), as it relates to a reclassification being effective for 3 fiscal years, shall not apply with respect to reclassifications made under this section.

(c) PROCESS FOR APPLICATIONS TO ENSURE THAT PROVISIONS APPLY BEGINNING OCTOBER 1, 2003.—The Secretary shall establish a process for the Medicare Geographic Classification Review Board to accept, and make determinations with respect to, applications that are filed by applicable hospitals within 90 days of the date of enactment of this section to reclassify based on the provisions of this section in order to ensure that such provisions shall apply to payments under such section 1886(d) for discharges occurring on or after October 1, 2003.

(d) ADJUSTMENTS TO ENSURE BUDGET NEUTRALITY.—If 1 or more applicable hospital's applications are approved pursuant to the process under subsection (c), the Secretary shall make a proportional adjustment in the standardized amounts determined under paragraph (3) of such section 1886(d) for payments for discharges occurring in fiscal year 2004 to ensure that approval of such applications does not result in aggregate payments under such section 1886(d) that are greater or less than those that would otherwise be made if this section had not been enacted.

SA 1022. Mr. BROWNBACK submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

SEC. . This Act may be cited as the ''Quality Cancer Care Preservation Act''.

SEC. . MEDICARE PAYMENT FOR DRUGS AND BIOLOGICALS.

(a) IN GENERAL.—Section 1842(o)(1) of the Social Security Act (42 U.S.C. 1395u(o)(1)) is amended by striking ''95 percent of the average wholesale price'' and inserting ''the payment amount specified in section 1834(n)(2)''.

(b) DETERMINATION OF PAYMENT AMOUNT.—Section 1834 of such Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

''(n) PAYMENT FOR DRUGS AND BIOLOGICALS—

''(1) REPORTS BY MANUFACTURERS—

''(A) IN GENERAL.—Every drug manufacturer shall report to the Secretary, in the manner prescribed in this paragraph, its average sales price (as defined in subparagraph (B)) in the United States during each calendar quarter for drugs and biologicals covered under this part.

''(B) DEFINITIONS.—For purposes of this subsection—

''(i) the term ''manufacturer'' means, with respect to a drug or biological, the entity identified by the Labeler Code portion of the National Drug Code of such drug or biological; and

''(ii) the term ''average sales price'' means the weighted average of all final sales prices to all purchasers, excluding sales specified in subparagraph (C). In determining such average sales prices, such prices shall be net of volume discounts, chargebacks, short-dated product discounts, free goods contingent on purchases, rebates (other than those made or authorized under section 1927), and all other price concessions that result in a reduction of the ultimate cost to the purchaser.

''(C) CONSIDERATION IN CALCULATION OF AVERAGE SALES PRICES.—The calculation of average sales price under this subsection shall not include-

''(i) prices that are excluded from the calculation of ''best price'' under section 1927(c)(1)(C);

''(ii) prices offered to entities that are considered under subparagraph (B)(i) to be the manufacturers of the drugs or biologicals involved;

''(iii) prices offered by a manufacturer to a hospital, nursing facility, hospice, or health maintenance organization;

''(iv) prices to governmental entities; and

''(v) nominal prices offered to bona fide charitable organizations.

''(D) QUARTERLY REPORTS.—Each manufacturer shall submit the report required by subparagraph (A) to the Secretary by electronic means no later than 30 days after the end of a calendar quarter with respect to sales that occurred during such quarter. The Secretary shall prescribe the format and other requirements for the report.

''(E) Enforcement.—

''(i) FAILURE TO TIMELY REPORT.—The Secretary may impose a civil monetary penalty in an amount not to exceed $100,000 on a manufacturer that fails to provide the information required under this paragraph on a timely basis and in the manner required.

''(ii) FALSE INFORMATION.—For each item of false information, the Secretary may impose a civil money penalty in an amount not to exceed $100,000 on a manufacturer that knowingly provides false information under this paragraph.

''(iii) MANNER OF IMPOSITION OF CIVIL MONETARY PENALTIES.—The provisions in section 1128A (other than subsections (a) and (b)) shall apply to a civil monetary penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

''(F) CONFIDENTIALITY OF INFORMATION.—Notwithstanding any other provision of law, information disclosed by manufacturers under this paragraph is confidential and shall not be disclosed by the Secretary in any form other than as specifically authorized by this subsection.

''(2) CALCULATION OF PAYMENT AMOUNT—

''(A) IN GENERAL.—Except as otherwise provided in this paragraph, the payment amount for a drug or biological furnished during a calendar quarter shall be 120 percent of the average sales price of the drug or biological for the second preceding calendar quarter as determined under paragraph (1).

''(B) METHODOLOGY.—In determining payment amounts under subparagraph (A), the Secretary may, in the Secretary's discretion, use either the average sales price for each drug or biological by specific drug or biological, or a cumulative average sales price based on sales data for all versions of a multiple-source drug that the Secretary, acting through the Food and Drug Administration, has determined are therapeutically equivalent (as evidenced by ''A'' ratings in the publication Approved Drug Products with Therapeutic Equivalence Evaluations).

''(C) INCREASE TO REFLECT ADDITIONAL. COSTS ATTRIBUTABLE TO STATE AND LOCAL TAXES.—In the case of a drug or biological that was subject to a State or local sales tax or gross receipts tax when administered or dispensed, the payment amount determined under subparagraph (A) shall be increased by the amount of such tax paid with respect to such drug or biological.

''(D) SUBSTITUTION OF HIGHER PAYMENT AMOUNT.—If a physician's, supplier's, or any other person's claim for payment for services under this Act documents that the price paid for a drug or biological was greater than the payment amount determined under subparagraph (A), the actual amount paid shall be substituted for the payment amount determined under subparagraph (A), unless the Secretary determines that the actual amount paid was unreasonable under the circumstances.

''(E) INCREASE FOR BAD DEBT AND CERTAIN OTHER COSTS.—Upon the submission of supporting information, the Secretary shall make an additional payment to a physician or supplier to cover—

''(i) uncollectible deductibles and coinsurance due from Medicare beneficiaries with respect to drugs and biologicals furnished to such beneficiaries; and

''(ii) costs incurred in procuring and billing for drugs and biologicals furnished to Medicare beneficiaries.''.

SEC. . MEDICARE PAYMENT FOR DRUG ADMINISTRATION SERVICES.

(a) GENERAL.—The Secretary of Health and Human Services (hereafter in this Act referred to as ''the Secretary'') shall revise the practice expense relative value units for drug administration services for years beginning with the year 2005 in accordance with this section. For purposes of this section, ''drug administration services'' includes chemotherapy administration services, therapeutic and diagnostic infusions and injections, and such other services as the Secretary specifies.

(b) DIRECT COSTS EQUAL TO 100 PERCENT OF CPEP ESTIMATES.— Using the information, including estimates of clinical staff time, developed in the clinical practice expert panel process, including refinements by American Medical Association committees, the Secretary shall estimate the costs of the nursing and other clinical staff, supplies, and procedure-specific equipment (exceeding a cost specified by the Secretary) used in furnishing each type of drug administration service. The Secretary shall utilize without revision the minutes of clinical staff time determined in such process. The Secretary shall convert the information from such process to estimated costs by applying the most current available data on staff salary, supply, and equipment costs, and such costs shall be updated to 2005 based on estimated changes in prices since the date of such data.

(c) TOTAL PRACTICE EXPENSES.—The Secretary shall estimate the total practice expenses of each drug administration service by assuming that the direct costs for the service determined under subsection (b) are 33.2 percent of such total practice expenses.

(d) CONVERSION TO RELATIVE VALUE UNITS.—The Secretary shall convert the total practice expenses determined under subsection (c) to practice expense relative value units for each drug administration service by dividing such expenses by the conversion factor that will be in effect for the physician fee schedule for 2005. The relative value units as so determined shall be used in determining the fee schedule amounts paid for drug administration services under section 1848 of the Social Security Act (42 U.S.C. 1395w–4).

(e) UPDATES.—For years after 2005, the relative values determined under subsection (d) shall continue in effect except that the Secretary shall revise them as necessary to maintain their accuracy, provided that such revisions are consistent with the methodology set forth in this section.

(f) MULTIPLE PUSHES.—In establishing the payment amounts under this section, the Secretary shall establish the payment amount for intravenous chemotherapy administration by push technique based of the administration of a single drug. The Secretary shall make the same payment for each additional drug administered by push technique during the same encounter, except to the extent that the Secretary finds that the cost of administering additional drugs is less than the cost of administering the first drug.

SEC. . PAYMENTS FOR CHEMOTHERAPY SUPPORT SERVICES.

(a) GENERAL.—Beginning in the year 2005, the Secretary shall recognize and make payments under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for chemotherapy support services furnished incident to physicians' services. For the purposes of this section, ''chemotherapy support services'' are services furnished by the staff of physicians to patients undergoing treatment for cancer that were not included in the computation of clinical staff costs under section 3(b). Such services include social worker services, nutrition counseling, psychosocial services, and similar services.

(b) DIRECT COSTS.—The Secretary shall estimate the cost of the salary and benefits of staff furnishing chemotherapy support services as they are provided in oncology practices that furnish these services to cancer patients in a manner that is considered to be high quality care. The estimate shall be based on the weekly cost of such services per patient receiving chemotherapy.

(c) TOTAL COSTS.—The Secretary shall estimate the total practice expenses of chemotherapy support services by assuming that the direct costs for the service determined under subsection (b) are 33.2 percent of such total practice expenses.

(d) CONVERSION TO RELATIVE VALUE UNITS.—The Secretary shall convert the total practice expenses determined under subsection (c) to practice expense relative value units for chemotherapy support services by dividing such expenses by the conversion factor that will be in effect for the physician fee schedule for 2005. The relative value units as so determined shall be used in determining the fee schedule amounts paid for chemotherapy support services under such section 1848.

(e) UPDATES.—For the years after 2005, the relative values determined under subsection (d) shall continue in effect except that the Secretary shall revise them as necessary to maintain their accuracy, provided that such revisions are consistent with the methodology set forth in this section.

SEC. . CANCER THERAPY MANAGEMENT SERVICES.

The Secretary shall recognize and establish a payment amount for the service of cancer therapy management to account for the greater pre-service and post-service work associated with visits and consultations conducted by physicians treating cancer patients compared to typical visits and consultations. The payment amount may vary by the level and type of the related visit or consultation.

SEC. . OTHER SERVICES WITHOUT PHYSICIAN WORK RELATIVE VALUE UNITS.

The Secretary shall develop a revised methodology for determining the payment amounts for services that are paid under the fee schedule established by section 1848 of the Social Security Act (42 U.S.C. 1395w–4) and that do not have physician work relative value units, including radiation oncology services. Such methodology shall result in payment amounts that fully cover the costs of furnishing such services. Until such time as the methodology for such services is revised and implemented, all such services shall be protected from further payment cuts due to factors such as shifts in utilization or removal of any one specialty's services that are paid under the fee schedule established by such section 1848 and that do not have physician work relative value units.

SEC. . PHYSICIAN SUPERVISION OF SERVICES.

Section 1834 of the Social Security Act (42 U.S.C. 1395m), as amended by section 2, is further amended by adding at the end the following new subsection:

''(o) SUPERVISION REQUIREMENTS—If the Secretary requires direct supervision of a service by a physician, that supervision requirement may be fulfilled by one or more physicians other than the physician who ordered the service. If the supervising physician is different from the ordering physician for a particular service, the ordering physician may nevertheless bill for such service provided that the medical records for the service involved identify the supervising physician or physicians.''.

SEC. . REPORT TO CONGRESS.

No later than April 1, 2004, the Secretary shall submit to Congress a report on the payment amounts that are projected to be adopted under sections 2, 3, 4, and 5 of this Act.

SEC. . INSTITUTE OF MEDICINE STUDY.

(a) GENERAL.—The Secretary of Health and Human Services shall request the Institute of Medicine to conduct the study described in this section.

(b) BASELINE STUDY.—The first phase of the study shall include the following objectives:

(1) An assessment of the extent to which the current Medicare payment system, prior to implementation of the amendments made by this Act, facilitates appropriate access to

care by cancer patients in the various treatment settings.

(2) The identification of the comprehensive range of services furnished to cancer patients in the outpatient setting, including support services such as psychosocial services and counseling, and recommendations regarding the types of services that ought to be furnished to Medicare patients with cancer.

(3) A discussion of the practice standards necessary to assure the safe provision of services to cancer patients.

(4) An analysis of the extent to which the current Medicare payment system supports the role of nurses in the provision of oncology services and recommendations for any necessary improvements in the payment system in that respect.

(5) The development of a framework for assessing how the amendments made by this act affect the provision of care to Medicare patients with cancer in the various treatment settings.

(c) SECOND PHASE OF STUDY.—After the implementation of the amendments made by this Act, the study shall determine whether and how those amendments affected the provision of care to Medicare patients with cancer.

(d) CONSULTATION.—The Institute of Medicine shall consult with the National Cancer Policy Board and organizations representing cancer patients and survivors, oncologists, oncology nurses, social workers, cancer centers, and other healthcare professionals who treat cancer patients in planning and carrying out this study.

(e) DUE DATES—

(1) The study required by subsection (b) shall be submitted to the Congress and the Secretary of Health and Human Services no later than June 30, 2004.

(2) The study required by subsection (c) shall be submitted to the Congress and the Secretary of Health and Human Services no later than December 31, 2006.

SEC. 10. EFFECTIVE DATES.

(a) GENERAL.—Except as provided in this section, the provisions of this Act shall apply to drugs, biologicals, and services furnished on or after January 1, 2005.

(b) REPORTS FROM MANUFACTURERS.—The first report by manufacturers required by the provisions of section 2 shall be submitted no later than October 30, 2004, with respect to sales that occurred in the quarter ending September 30, 2004.

(c) SUPERVISION OF SERVICES.—The amendment made by section 7 shall be effective upon enactment.

(d) SERVICES OTHER THAN DRUG ADMINISTRATION.—The Secretary shall implement the requirements of section 6 no later than January 1, 2005.

SA 1023. Ms. COLLINS submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in subtitle B of title IV, insert the following:

SEC. ___. DEMONSTRATION PROJECT TO CLARIFY THE DEFINITION OF HOMEBOUND.

(a) DEMONSTRATION PROJECT.—Not later than 180 days after the date of enactment of this Act, the Secretary shall conduct a two-year demonstration project under part B of title XVIII of the Social Security Act under which medicare beneficiaries with chronic conditions described in subsection (b) are deemed to be homebound for purposes of receiving home health services under the medicare program.

(b) MEDICARE BENEFICIARY DESCRIBED.—For purposes of subsection (a), a medicare beneficiary is eligible to be deemed to be homebound, without regard to the purpose, frequency, or duration of absences from the home, if the beneficiary—

(1) has been certified by one physician as an individual who has a permanent and severe condition that will not improve;

(2) requires the individual to receive assistance from another individual with at least 3 out of the 5 activities of daily living for the rest of the individual's life;

(3) requires 1 or more home health services to achieve a functional condition that gives the individual the ability to leave home; and

(4) requires technological assistance or the assistance of another person to leave the home.

(c) DEMONSTRATION PROJECT SITES.—The demonstration project established under this section shall be conducted in 3 States selected by the Secretary to represent the Northeast, Midwest, and Western regions of the United States.

(d) LIMITATION ON NUMBER OF PARTICIPANTS.—The aggregate number of such beneficiaries that may participate in the project may not exceed 15,000.

(e) DATA.—The Secretary shall collect such data on the demonstration project with respect to the provision of home health services to medicare beneficiaries that relates to quality of care, patient outcomes, and additional costs, if any, to the medicare program.

(f) REPORT TO CONGRESS.—Not later than 1 year after the date of the completion of the demonstration project under this section, the Secretary shall submit to Congress a report on the project using the data collected under subsection (e) and shall include—

(1) an examination of whether the provision of home health services to medicare beneficiaries under the project—

(A) adversely effects the provision of home health services under the medicare program; or

(B) directly causes an unreasonable increase of expenditures under the medicare program for the provision of such services that is directly attributable to such clarification;

(2) the specific data evidencing the amount of any increase in expenditures that is a directly attributable to the demonstration project (expressed both in absolute dollar terms and as a percentage) above expenditures that would otherwise have been incurred for home health services under the medicare program; and

(3) specific recommendations to exempt permanently and severely disabled homebound beneficiaries from restrictions on the length, frequency and purpose of their absences from the home to qualify for home health services without incurring additional unreasonable costs to the medicare program.

(g) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

(h) CONSTRUCTION.—Nothing in this section shall be construed as waiving any applicable civil monetary penalty, criminal penalty, or other remedy available to the Secretary under title XI or title XVIII of the Social Security Act for acts prohibited under such titles, including penalties for false certifications for purposes of receipt of items or services under the medicare program.

(i) AUTHORIZATION OF APPROPRIATIONS.—Payments for the costs of carrying out the demonstration project under this section shall be made from the Federal Supplementary Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t).

(j) DEFINITIONS.—In this section:

(1) MEDICARE BENEFICIARY.—The term ''medicare beneficiary'' means an individual who is enrolled under part B of title XVIII of the Social Security Act.

(2) HOME HEALTH SERVICES.—The term ''home health services'' has the meaning given such term in section 1861(m) of the Social Security Act (42 U.S.C. 1395x(m)).

(3) ACTIVITIES OF DAILY LIVING DEFINED.—The term ''activities of daily living'' means eating, toileting, transferring, bathing, and dressing.

(4) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

SA 1024. Mr. ENSIGN (for himself and Mrs. LINCOLN) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title IV, insert the following:

SEC. ___. OUTPATIENT THERAPY CAP REPEAL.

(a) IN GENERAL.—Section 1833 of the Social Security Act (42 U.S.C. 1395*l*) is amended by striking subsection (g).

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on January 1, 2005.

SA 1025. Mr. ENSIGN submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, insert the following:

SEC. ___. COST-BENEFIT EVALUATION OF SOCIAL HEALTH MAINTENANCE ORGANIZATION II DEMONSTRATION PROJECT AND EXTENSION OF PROJECT AUTHORITY.

(a) EXTENSION.—Notwithstanding any other provision of law, the Social Health Maintenance Organization II demonstration project described under section 2355(b)(1)(B) of the Deficit Reduction Act of 1984, as amended, shall be conducted for an additional period of 5 years beginning October 1, 2004 under applicable contractual provisions existing on December 31, 2002. Such demonstration project shall be evaluated by an independent organization in accordance with subsection (b). The report on the evaluation and related recommendations shall be provided as described in subsection (c).

(b) EVALUATION.—

(1) RESEARCH DESIGN.—The Secretary shall provide for a project research design that includes information on the Medicare beneficiaries who are participating in the project and on other Medicare beneficiaries who are covered under fee-for-service and other Medicare+Choice plans and that allows for an appropriate statistical analysis and evaluation of the demonstration project by an independent organization.

(2) DATA COLLECTION.—The Secretary shall require the Social Health Maintenance Organization II to comply with such data collection and reporting requirements as the Secretary determines necessary in order that the assessments can be made as described under subsection (c)(2); and

(3) DURATION.—The project evaluation period shall last for a period of 3 years.

(c) REPORT.—

(1) IN GENERAL.—The Secretary shall issue to the Congress a final report on the project not later than 9 months after the date of the completion of the evaluation period.

(2) CONTENTS OF REPORT.—The report under paragraph (1) shall include the following:

(A) A description of the demonstration project and the distinguishing characteristics of the Social Health Maintenance Organization II project, including the project's geriatric approach to patient care, extensive care coordination and patient assessments, provision of extended benefits to beneficiaries with targeted health risks, and risk adjusted payment methodology.

(B) An evaluation of—

(i) the cost-effectiveness of the project compared to the comparison group with respect to the extent of any delay or reduction in the incidence or length of stay in nursing homes or similar institutions and the estimated Medicare and Medicaid cost savings relating to such delay or reductions,

(ii) the extent to which the utilization of physician, home health, coordinated care, geriatric, prescription drug, extended care benefits and other services which are unique to the project result in any reduction in the incidence or length of inpatient stays and in the improvement or lessening in the deterioration of the physical status and mental health functioning of beneficiaries, and

(iii) the feasibility of replicating the elements of the Social Health Maintenance Organization II model under other Medicare+Choice plans.

To the extent feasible, an evaluation of the elements described in this subparagraph shall be conducted on a longitudinal basis for noninstitutionalized beneficiaries who are at high risk of hospitalization or institutionalization, for other noninstitutionalized beneficiaries who are not at high risk, and for institutionalized beneficiaries. To the extent feasible such evaluations shall be conducted for appropriate age and gender beneficiary categories.

(C) A description of the data and criteria and methodology used in conducting the evaluation.

(D) Any other information regarding the project that the Secretary determines to be appropriate and any recommendations the Secretary may make regarding the extent to which changes should be made in connection with the project or the extension of the project as a model under the Medicare+Choice program.

(d) DEFINITIONS.—In this section:

(1) DEMONSTRATION PROJECT.—The term ''demonstration project'' means the demonstration project described under subsection (a).

(2) MEDICARE BENEFICIARY.—The term ''Medicare beneficiary'' means an individual entitled to benefits under part A and covered under part B of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(3) MEDICARE.—The term ''Medicare'' means the health benefits program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(4) MEDICARE+CHOICE.—The term ''Medicare+Choice'' means the Medicare+Choice health benefits program described under part C of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), and for years after 2005, the MedicareAdvantage program described under such part.

(5) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(6) SOCIAL HEALTH MAINTENANCE ORGANIZATION II.—The term ''Social Health Maintenance Organization II'' means the project described under section 2355(b)(1)(B) of the Deficit Reduction Act of 1984, as amended.

(e) EFFECTIVE DATE.—The effective date of this section is the date of the enactment of this Act.

SA 1026. Mr. HAGEL (for himself, Mr. ENSIGN, Mr. LOTT, and Mr. INHOFE) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

(Purpose: To provide medicare beneficiaries with a drug discount card that ensures access to privately-negotiated discounts on drugs and protection against high and out-of-pocket drug costs)

Strike title I and insert the following:

TITLE I—MEDICARE PRESCRIPTION DRUG DISCOUNT

SEC. 101. VOLUNTARY MEDICARE PRESCRIPTION DRUG DISCOUNT AND SECURITY PROGRAM.

(a) ESTABLISHMENT OF PROGRAM.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended—

(1) by redesignating part D as part E; and

(2) by inserting after part C the following new part:

''PART D—VOLUNTARY MEDICARE PRESCRIPTION DRUG DISCOUNT AND SECURITY PROGRAM

''DEFINITIONS

''SEC. 1860. In this part:

''(1) COVERED DRUG.—

''(A) IN GENERAL.—Except as provided in this paragraph, the term 'covered drug' means—

''(i) a drug that may be dispensed only upon a prescription and that is described in subparagraph (A)(i) or (A)(ii) of section 1927(k)(2); or

''(ii) a biological product described in clauses (i) through (iii) of subparagraph (B) of such section or insulin described in subparagraph (C) of such section,

and such term includes a vaccine licensed under section 351 of the Public Health Service Act and any use of a covered drug for a medically accepted indication (as defined in section 1927(k)(6)).

''(B) EXCLUSIONS.—

''(i) IN GENERAL.—Such term does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2), other than subparagraph (E) thereof (relating to smoking cessation agents), or under section 1927(d)(3).

''(ii) AVOIDANCE OF DUPLICATE COVERAGE.—A drug prescribed for an individual that would otherwise be a covered drug under this part shall not be so considered if payment for such drug is available under part A or B for an individual entitled to benefits under part A and enrolled under part B.

''(C) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an individual that would otherwise be a covered drug under this part shall not be so considered under a plan if the plan excludes the drug under a formulary and such exclusion is not successfully appealed under section 1860D(a)(4)(B).

''(D) APPLICATION OF GENERAL EXCLUSION PROVISIONS.—A prescription drug discount card plan or Medicare+Choice plan may exclude from qualified prescription drug coverage any covered drug—

''(i) for which payment would not be made if section 1862(a) applied to part D; or

''(ii) which are not prescribed in accordance with the plan or this part.

Such exclusions are determinations subject to reconsideration and appeal pursuant to section 1860D(a)(4).

''(2) ELIGIBLE BENEFICIARY.—The term 'eligible beneficiary' means an individual who is—

''(A) eligible for benefits under part A or enrolled under part B; and

''(B) not eligible for prescription drug coverage under a State plan under the medicaid program under title XIX.

''(3) ELIGIBLE ENTITY.—The term 'eligible entity' means any—

''(A) pharmaceutical benefit management company;

''(B) wholesale pharmacy delivery system;

''(C) retail pharmacy delivery system;

''(D) insurer (including any issuer of a medicare supplemental policy under section 1882);

''(E) Medicare+Choice organization;

''(F) State (in conjunction with a pharmaceutical benefit management company);

''(G) employer-sponsored plan;

''(H) other entity that the Secretary determines to be appropriate to provide benefits under this part; or

''(I) combination of the entities described in subparagraphs (A) through (H).

''(4) POVERTY LINE.—The term 'poverty line' means the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

''(5) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services.

''ESTABLISHMENT OF PROGRAM

''SEC. 1860A. (a) PROVISION OF BENEFIT.—The Secretary shall establish a Medicare Prescription Drug Discount and Security Program under which the Secretary endorses prescription drug card plans offered by eligible entities in which eligible beneficiaries may voluntarily enroll and receive benefits under this part.

''(b) ENDORSEMENT OF PRESCRIPTION DRUG DISCOUNT CARD PLANS.—

''(1) IN GENERAL.—The Secretary shall endorse a prescription drug card plan offered by an eligible entity with a contract under this part if the eligible entity meets the requirements of this part with respect to that plan.

''(2) NATIONAL PLANS.—In addition to other types of plans, the Secretary may endorse national prescription drug plans under paragraph (1).

''(c) VOLUNTARY NATURE OF PROGRAM.—Nothing in this part shall be construed as requiring an eligible beneficiary to enroll in the program under this part.

''(d) FINANCING.—The costs of providing benefits under this part shall be payable from the Federal Supplementary Medical Insurance Trust Fund established under section 1841.

''ENROLLMENT

''SEC. 1860B. (a) ENROLLMENT UNDER PART D.—

''(1) ESTABLISHMENT OF PROCESS.—

''(A) IN GENERAL.—The Secretary shall establish a process through which an eligible beneficiary (including an eligible beneficiary enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization) may make an election to enroll under this part. Except as otherwise provided in this subsection, such process shall be similar to the process for enrollment under part B under section 1837.

''(B) REQUIREMENT OF ENROLLMENT.—An eligible beneficiary must enroll under this part in order to be eligible to receive the benefits under this part.

''(2) ENROLLMENT PERIODS.—

''(A) IN GENERAL.—Except as provided in this paragraph, an eligible beneficiary may not enroll in the program under this part during any period after the beneficiary's initial enrollment period under part B (as determined under section 1837).

''(B) SPECIAL ENROLLMENT PERIOD.—In the case of eligible beneficiaries that have recently lost eligibility for prescription drug coverage under a State plan under the medicaid program under title XIX, the Secretary shall establish a special enrollment period in which such beneficiaries may enroll under this part.

''(C) OPEN ENROLLMENT PERIOD IN 2005 FOR CURRENT BENEFICIARIES.—The Secretary shall establish a period, which shall begin on the date on which the Secretary first begins to accept elections for enrollment under this part, during which any eligible beneficiary may—

''(i) enroll under this part; or

''(ii) enroll or reenroll under this part after having previously declined or terminated such enrollment.

''(3) PERIOD OF COVERAGE.—

''(A) IN GENERAL.—Except as provided in subparagraph (B) and subject to subparagraph (C), an eligible beneficiary's coverage under the program under this part shall be effective for the period provided under section 1838, as if that section applied to the program under this part.

''(B) ENROLLMENT DURING OPEN AND SPECIAL ENROLLMENT.—Subject to subparagraph (C), an eligible beneficiary who enrolls under the program under this part under subparagraph (B) or (C) of paragraph (2) shall be entitled to the benefits under this part beginning on the first day of the month following the month in which such enrollment occurs.

''(4) PART D COVERAGE TERMINATED BY TERMINATION OF COVERAGE UNDER PARTS A AND B OR ELIGIBILITY FOR MEDICAL ASSISTANCE.—

''(A) IN GENERAL.—In addition to the causes of termination specified in section 1838, the Secretary shall terminate an individual's coverage under this part if the individual is—

''(i) no longer enrolled in part A or B; or

''(ii) eligible for prescription drug coverage under a State plan under the medicaid program under title XIX.

''(B) EFFECTIVE DATE.—The termination described in subparagraph (A) shall be effective on the effective date of—

''(i) the termination of coverage under part A or (if later) under part B; or

''(ii) the coverage under title XIX.

''(b) ENROLLMENT WITH ELIGIBLE ENTITY.—

''(1) PROCESS.—The Secretary shall establish a process through which an eligible beneficiary who is enrolled under this part shall make an annual election to enroll in a prescription drug card plan offered by an eligible entity that has been awarded a contract under this part and serves the geographic area in which the beneficiary resides.

''(2) ELECTION PERIODS.—

''(A) IN GENERAL.—Except as provided in this paragraph, the election periods under this subsection shall be the same as the coverage election periods under the Medicare+Choice program under section 1851(e), including—

''(i) annual coordinated election periods; and

''(ii) special election periods.

In applying the last sentence of section 1851(e)(4) (relating to discontinuance of a Medicare+Choice election during the first year of eligibility) under this subparagraph, in the case of an election described in such section in which the individual had elected or is provided qualified prescription drug coverage at the time of such first enrollment, the individual shall be permitted to enroll in a prescription drug card plan under this part at the time of the election of coverage under the original fee-for-service plan.

''(B) INITIAL ELECTION PERIODS.—

''(i) INDIVIDUALS CURRENTLY COVERED.—In the case of an individual who is entitled to benefits under part A or enrolled under part B as of November 1, 2005, there shall be an initial election period of 6 months beginning on that date.

''(ii) INDIVIDUAL COVERED IN FUTURE.—In the case of an individual who is first entitled to benefits under part A or enrolled under part B after such date, there shall be an initial election period which is the same as the initial enrollment period under section 1837(d).

''(C) ADDITIONAL SPECIAL ELECTION PERIODS.—The Administrator shall establish special election periods—

''(i) in cases of individuals who have and involuntarily lose prescription drug coverage described in paragraph (3);

''(ii) in cases described in section 1837(h) (relating to errors in enrollment), in the same manner as such section applies to part B; and

''(iii) in the case of an individual who meets such exceptional conditions (including conditions provided under section 1851(e)(4)(D)) as the Secretary may provide.

''(D) ENROLLMENT WITH ONE PLAN ONLY.—The rules established under subparagraph (B) shall ensure that an eligible beneficiary may only enroll in 1 prescription drug card plan offered by an eligible entity per year.

''(3) MEDICARE+CHOICE ENROLLEES.—An eligible beneficiary who is enrolled under this part and enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization must enroll in a prescription drug discount card plan offered by an eligible entity in order to receive benefits under this part. The beneficiary may elect to receive such benefits through the Medicare+Choice organization in which the beneficiary is enrolled if the organization has been awarded a contract under this part.

''(4) CONTINUOUS PRESCRIPTION DRUG COVERAGE.—An individual is considered for purposes of this part to be maintaining continuous prescription drug coverage on and after the date the individual first qualifies to elect prescription drug coverage under this part if the individual establishes that as of such date the individual is covered under any of the following prescription drug coverage and before the date that is the last day of the 63-day period that begins on the date of termination of the particular prescription drug coverage involved (regardless of whether the individual subsequently obtains any of the following prescription drug coverage):

''(A) COVERAGE UNDER PRESCRIPTION DRUG CARD PLAN OR MEDICARE+CHOICE PLAN.—Prescription drug coverage under a prescription drug card plan under this part or under a Medicare+Choice plan.

''(B) MEDICAID PRESCRIPTION DRUG COVERAGE.—Prescription drug coverage under a medicaid plan under title XIX, including through the Program of All-inclusive Care for the Elderly (PACE) under section 1934, through a social health maintenance organization (referred to in section 4104(c) of the Balanced Budget Act of 1997), or through a Medicare+Choice project that demonstrates the application of capitation payment rates for frail elderly medicare beneficiaries through the use of a interdisciplinary team and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved.

''(C) PRESCRIPTION DRUG COVERAGE UNDER GROUP HEALTH PLAN.—Any prescription drug coverage under a group health plan, including a health benefits plan under the Federal Employees Health Benefit Plan under chapter 89 of title 5, United States Code, and a qualified retiree prescription drug plan (as defined by the Secretary), but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a prescription drug card plan under this part.

''(D) PRESCRIPTION DRUG COVERAGE UNDER CERTAIN MEDIGAP POLICIES.—Coverage under a medicare supplemental policy under section 1882 that provides benefits for prescription drugs (whether or not such coverage conforms to the standards for packages of benefits under section 1882(p)(1)) and if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a prescription drug card plan under this part.

''(E) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—Coverage of prescription drugs under a State pharmaceutical assistance program, but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a prescription drug card plan under this part.

''(F) VETERANS' COVERAGE OF PRESCRIPTION DRUGS.—Coverage of prescription drugs for veterans under chapter 17 of title 38, United States Code, but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a prescription drug card plan under this part.

For purposes of carrying out this paragraph, the certifications of the type described in sections 2701(e) of the Public Health Service Act and in section 9801(e) of the Internal Revenue Code of 1986 shall also include a statement for the period of coverage of whether the individual involved had prescription drug coverage described in this paragraph.

''(5) COMPETITION.—Each eligible entity with a contract under this part shall compete for the enrollment of beneficiaries in a prescription drug card plan offered by the entity on the basis of discounts, formularies, pharmacy networks, and other services provided for under the contract.

''PROVIDING ENROLLMENT AND COVERAGE INFORMATION TO BENEFICIARIES

''SEC. 1860C. (a) ACTIVITIES.—The Secretary shall provide for activities under this part to broadly disseminate information to eligible beneficiaries (and prospective eligible beneficiaries) regarding enrollment under this part and the prescription drug card plans offered by eligible entities with a contract under this part.

''(b) SPECIAL RULE FOR FIRST ENROLLMENT UNDER THE PROGRAM.—To the extent practicable, the activities described in subsection (a) shall ensure that eligible beneficiaries are provided with such information at least 60 days prior to the first enrollment period described in section 1860B(c).

''ENROLLEE PROTECTIONS

''SEC. 1860D. (a) REQUIREMENTS FOR ALL ELIGIBLE ENTITIES.—Each eligible entity shall meet the following requirements:

''(1) GUARANTEED ISSUANCE AND NONDISCRIMINATION.—

''(A) GUARANTEED ISSUANCE.—

''(i) IN GENERAL.—An eligible beneficiary who is eligible to enroll in a prescription drug card plan offered by an eligible entity under section 1860B(b) for prescription drug coverage under this part at a time during which elections are accepted under this part with respect to the coverage shall not be denied enrollment based on any health status-related factor (described in section 2702(a)(1) of the Public Health Service Act) or any other factor.

''(ii) MEDICARE+CHOICE LIMITATIONS PERMITTED.—The provisions of paragraphs (2) and (3) (other than subparagraph (C)(i), relating to default enrollment) of section 1851(g) (relating to priority and limitation on termination of election) shall apply to eligible entities under this subsection.

''(B) NONDISCRIMINATION.—An eligible entity offering prescription drug coverage under this part shall not establish a service area in a manner that would discriminate based on health or economic status of potential enrollees.

''(2) DISCLOSURE OF INFORMATION.—

''(A) INFORMATION.—

''(i) GENERAL INFORMATION.—Each eligible entity with a contract under this part to provide a prescription drug card plan shall disclose, in a clear, accurate, and standardized form to each eligible beneficiary enrolled in a prescription drug discount card program offered by such entity under this part at the time of enrollment and at least annually thereafter, the information described in section 1852(c)(1) relating to such prescription drug coverage.

''(ii) SPECIFIC INFORMATION.—In addition to the information described in clause (i), each eligible entity with a contract under this part shall disclose the following:

''(I) How enrollees will have access to covered drugs, including access to such drugs through pharmacy networks.

''(II) How any formulary used by the eligible entity functions.

''(III) Information on grievance and appeals procedures.

''(IV) Information on enrollment fees and prices charged to the enrollee for covered drugs.

''(V) Any other information that the Secretary determines is necessary to promote informed choices by eligible beneficiaries among eligible entities.

''(B) DISCLOSURE UPON REQUEST OF GENERAL COVERAGE, UTILIZATION, AND GRIEVANCE INFORMATION.—Upon request of an eligible beneficiary, the eligible entity shall provide the information described in paragraph (3) to such beneficiary.

''(C) RESPONSE TO BENEFICIARY QUESTIONS.—Each eligible entity offering a prescription drug discount card plan under this part shall have a mechanism for providing specific information to enrollees upon request. The entity shall make available, through an Internet website and, upon request, in writing, information on specific changes in its formulary.

''(3) GRIEVANCE MECHANISM, COVERAGE DETERMINATIONS, AND RECONSIDERATIONS.—

''(A) IN GENERAL.—With respect to the benefit under this part, each eligible entity offering a prescription drug discount card plan shall provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the eligible entity provides covered benefits) and enrollees with prescription drug card plans of the eligible entity under this part in accordance with section 1852(f).

''(B) APPLICATION OF COVERAGE DETERMINATION AND RECONSIDERATION PROVISIONS.—Each eligible entity shall meet the requirements of paragraphs (1) through (3) of section 1852(g) with respect to covered benefits under the prescription drug card plan it offers under this part in the same manner as such requirements apply to a Medicare+Choice organization with respect to benefits it offers under a Medicare+Choice plan under part C.

''(C) REQUEST FOR REVIEW OF TIERED FORMULARY DETERMINATIONS.—In the case of a prescription drug card plan offered by an eligible entity that provides for tiered cost-sharing for drugs included within a formulary and provides lower cost-sharing for preferred drugs included within the formulary, an individual who is enrolled in the plan may request coverage of a nonpreferred drug under the terms applicable for preferred drugs if the prescribing physician determines that the preferred drug for treatment of the same condition is not as effective for the individual or has adverse effects for the individual.

''(4) APPEALS.—

''(A) IN GENERAL.—Subject to subparagraph (B), each eligible entity offering a prescription drug card plan shall meet the requirements of paragraphs (4) and (5) of section 1852(g) with respect to drugs not included on any formulary in the same manner as such requirements apply to a Medicare+Choice organization with respect to benefits it offers under a Medicare+Choice plan under part C.

''(B) FORMULARY DETERMINATIONS.—An individual who is enrolled in a prescription drug card plan offered by an eligible entity may appeal to obtain coverage under this part for a covered drug that is not on a formulary of the eligible entity if the prescribing physician determines that the formulary drug for treatment of the same condition is not as effective for the individual or has adverse effects for the individual.

''(5) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—Each eligible entity offering a prescription drug discount card plan shall meet the requirements of the Health Insurance Portability and Accountability Act of 1996.

''(b) ELIGIBLE ENTITIES OFFERING A DISCOUNT CARD PROGRAM.—If an eligible entity offers a discount card program under this part, in addition to the requirements under subsection (a), the entity shall meet the following requirements:

''(1) ACCESS TO COVERED BENEFITS.—

''(A) ASSURING PHARMACY ACCESS.—

''(i) IN GENERAL.—The eligible entity offering the prescription drug discount card plan shall secure the participation in its network of a sufficient number of pharmacies that dispense (other than by mail order) drugs directly to patients to ensure convenient access (as determined by the Secretary and including adequate emergency access) for enrolled beneficiaries, in accordance with standards established under section 1860D(a)(3) that ensure such convenient access.

''(ii) USE OF POINT-OF-SERVICE SYSTEM.—Each eligible entity offering a prescription drug discount card plan shall establish an optional point-of-service method of operation under which—

''(I) the plan provides access to any or all pharmacies that are not participating pharmacies in its network; and

''(II) discounts under the plan may not be available.

The additional copayments so charged shall not be counted as out-of-pocket expenses for purposes of section 1860F(b).

''(B) USE OF STANDARDIZED TECHNOLOGY.—

''(i) IN GENERAL.—Each eligible entity offering a prescription drug discount card plan shall issue (and reissue, as appropriate) such a card (or other technology) that may be used by an enrolled beneficiary to assure access to negotiated prices under section 1860F(a) for the purchase of prescription drugs for which coverage is not otherwise provided under the prescription drug discount card plan.

''(ii) STANDARDS.—The Secretary shall provide for the development of national standards relating to a standardized format for the card or other technology referred to in clause (i). Such standards shall be compatible with standards established under part C of title XI.

''(C) REQUIREMENTS ON DEVELOPMENT AND APPLICATION OF FORMULARIES.—If an eligible entity that offers a prescription drug discount card plan uses a formulary, the following requirements must be met:

''(i) PHARMACY AND THERAPEUTIC (P&T) COMMITTEE.—The eligible entity must establish a pharmacy and therapeutic committee that develops and reviews the formulary. Such committee shall include at least 1 physician and at least 1 pharmacist both with expertise in the care of elderly or disabled persons and a majority of its members shall consist of individuals who are a physician or a practicing pharmacist (or both).

''(ii) FORMULARY DEVELOPMENT.—In developing and reviewing the formulary, the committee shall base clinical decisions on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, such as randomized clinical trials, pharmacoeconomic studies, outcomes research data, and such other information as the committee determines to be appropriate.

''(iii) INCLUSION OF DRUGS IN ALL THERAPEUTIC CATEGORIES.—The formulary must include drugs within each therapeutic category and class of covered drugs (although not necessarily for all drugs within such categories and classes).

''(iv) PROVIDER EDUCATION.—The committee shall establish policies and procedures to educate and inform health care providers concerning the formulary.

''(v) NOTICE BEFORE REMOVING DRUGS FROM FORMULARY.—Any removal of a drug from a formulary shall take effect only after appropriate notice is made available to beneficiaries and physicians.

''(vi) GRIEVANCES AND APPEALS RELATING TO APPLICATION OF FORMULARIES.—For provisions relating to grievances and appeals of coverage, see paragraphs (3) and (4) of section 1860D(a).

''(2) COST AND UTILIZATION MANAGEMENT; QUALITY ASSURANCE; MEDICATION THERAPY MANAGEMENT PROGRAM.—

''(A) IN GENERAL.—Each eligible entity offering a prescription drug discount card plan shall have in place with respect to covered drugs—

''(i) an effective cost and drug utilization management program, including medically appropriate incentives to use generic drugs and therapeutic interchange, when appropriate;

''(ii) quality assurance measures and systems to reduce medical errors and adverse drug interactions, including a medication therapy management program described in subparagraph (B); and

''(iii) a program to control fraud, abuse, and waste.

Nothing in this section shall be construed as impairing an eligible entity from applying cost management tools (including differential payments) under all methods of operation.

''(B) MEDICATION THERAPY MANAGEMENT PROGRAM.—

''(i) IN GENERAL.—A medication therapy management program described in this paragraph is a program of drug therapy management and medication administration that is

designed to ensure, with respect to beneficiaries with chronic diseases (such as diabetes, asthma, hypertension, and congestive heart failure) or multiple prescriptions, that covered drugs under the prescription drug discount card plan are appropriately used to achieve therapeutic goals and reduce the risk of adverse events, including adverse drug interactions.

''(ii) ELEMENTS.—Such program may include—

''(I) enhanced beneficiary understanding of such appropriate use through beneficiary education, counseling, and other appropriate means;

''(II) increased beneficiary adherence with prescription medication regimens through medication refill reminders, special packaging, and other appropriate means; and

''(III) detection of patterns of overuse and underuse of prescription drugs.

''(iii) DEVELOPMENT OF PROGRAM IN COOPERATION WITH LICENSED PHARMACISTS.—The program shall be developed in cooperation with licensed pharmacists and physicians.

''(iv) CONSIDERATIONS IN PHARMACY FEES.—Each eligible entity offering a prescription drug discount card plan shall take into account, in establishing fees for pharmacists and others providing services under the medication therapy management program, the resources and time used in implementing the program.

''(C) TREATMENT OF ACCREDITATION.—Section 1852(e)(4) (relating to treatment of accreditation) shall apply to prescription drug discount card plans under this part with respect to the following requirements, in the same manner as they apply to Medicare+Choice plans under part C with respect to the requirements described in a clause of section 1852(e)(4)(B):

''(i) Paragraph (1) (including quality assurance), including any medication therapy management program under paragraph (2).

''(ii) Subsection (c)(1) (relating to access to covered benefits).

''(iii) Subsection (g) (relating to confidentiality and accuracy of enrollee records).

''(D) PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR EQUIVALENT DRUGS.—Each eligible entity offering a prescription drug discount card plan shall provide that each pharmacy or other dispenser that arranges for the dispensing of a covered drug shall inform the beneficiary at the time of purchase of the drug of any differential between the price of the prescribed drug to the enrollee and the price of the lowest cost drug covered under the plan that is therapeutically equivalent and bioequivalent.

''ANNUAL ENROLLMENT FEE

''SEC. 1860E. (a) AMOUNT.—

''(1) IN GENERAL.—Except as provided in subsection (c), enrollment under the program under this part is conditioned upon payment of an annual enrollment fee of $25.

''(2) ANNUAL PERCENTAGE INCREASE.—

''(A) IN GENERAL.—In the case of any calendar year beginning after 2006, the dollar amount in paragraph (1) shall be increased by an amount equal to—

''(i) such dollar amount; multiplied by

''(ii) the inflation adjustment.

''(B) INFLATION ADJUSTMENT.—For purposes of subparagraph (A)(ii), the inflation adjustment for any calendar year is the percentage (if any) by which—

''(i) the average per capita aggregate expenditures for covered drugs in the United States for medicare beneficiaries, as determined by the Secretary for the 12-month period ending in July of the previous year; exceeds

''(ii) such aggregate expenditures for the 12-month period ending with July 2005.

''(C) ROUNDING.—If any increase determined under clause (ii) is not a multiple of $1, such increase shall be rounded to the nearest multiple of $1.

''(b) COLLECTION OF ANNUAL ENROLLMENT FEE.—

''(1) IN GENERAL.—Unless the eligible beneficiary makes an election under paragraph (2), the annual enrollment fee described in subsection (a) shall be collected and credited to the Federal Supplementary Medical Insurance Trust Fund in the same manner as the monthly premium determined under section 1839 is collected and credited to such Trust Fund under section 1840.

''(2) DIRECT PAYMENT.—An eligible beneficiary may elect to pay the annual enrollment fee directly or in any other manner approved by the Secretary. The Secretary shall establish procedures for making such an election.

''(c) WAIVER.—The Secretary shall waive the enrollment fee described in subsection (a) in the case of an eligible beneficiary whose income is below 200 percent of the poverty line.

''BENEFITS UNDER THE PROGRAM

''SEC. 1860F. (a) ACCESS TO NEGOTIATED PRICES.—

''(1) NEGOTIATED PRICES.—

''(A) IN GENERAL.—Subject to subparagraph (B), each prescription drug card plan offering a discount card program by an eligible entity with a contract under this part shall provide each eligible beneficiary enrolled in such plan with access to negotiated prices (including applicable discounts) for such prescription drugs as the eligible entity determines appropriate. Such discounts may include discounts for nonformulary drugs. If such a beneficiary becomes eligible for the catastrophic benefit under subsection (b), the negotiated prices (including applicable discounts) shall continue to be available to the beneficiary for those prescription drugs for which payment may not be made under section 1860H(b). For purposes of this subparagraph, the term 'prescription drugs' is not limited to covered drugs, but does not include any over-the-counter drug that is not a covered drug.

''(B) LIMITATIONS.—

''(i) FORMULARY RESTRICTIONS.—Insofar as an eligible entity with a contract under this part uses a formulary, the negotiated prices (including applicable discounts) for nonformulary drugs may differ.

''(ii) AVOIDANCE OF DUPLICATE COVERAGE.—The negotiated prices (including applicable discounts) for prescription drugs shall not be available for any drug prescribed for an eligible beneficiary if payment for the drug is available under part A or B (but such negotiated prices shall be available if payment under part A or B is not available because the beneficiary has not met the deductible or has exhausted benefits under part A or B).

''(2) DISCOUNT CARD.—The Secretary shall develop a uniform standard card format to be issued by each eligible entity offering a prescription drug discount card plan that shall be used by an enrolled beneficiary to ensure the access of such beneficiary to negotiated prices under paragraph (1).

''(3) ENSURING DISCOUNTS IN ALL AREAS.—The Secretary shall develop procedures that ensure that each eligible beneficiary that resides in an area where no prescription drug discount card plans are available is provided with access to negotiated prices for prescription drugs (including applicable discounts).

''(b) CATASTROPHIC BENEFIT.—

''(1) TEN PERCENT COST-SHARING.—Subject to any formulary used by the prescription drug discount card program in which the eligible beneficiary is enrolled, the catastrophic benefit shall provide benefits with cost-sharing that is equal to 10 percent of the negotiated price (taking into account any applicable discounts) of each drug dispensed to such beneficiary after the beneficiary has incurred costs (as described in paragraph (3)) for covered drugs in a year equal to the applicable annual out-of-pocket limit specified in paragraph (2).

''(2) ANNUAL OUT-OF-POCKET LIMITS.—For purposes of this part, the annual out-of-pocket limits specified in this paragraph are as follows:

''(A) BENEFICIARIES WITH ANNUAL INCOMES BELOW 200 PERCENT OF THE POVERTY LINE.—In the case of an eligible beneficiary whose income (as determined under section 1860I) is below 200 percent of the poverty line, the annual out-of-pocket limit is equal to $1,500.

''(B) BENEFICIARIES WITH ANNUAL INCOMES BETWEEN 200 AND 400 PERCENT OF THE POVERTY LINE.—In the case of an eligible beneficiary whose income (as so determined) equals or exceeds 200 percent, but does not exceed 400 percent, of the poverty line, the annual out-of-pocket limit is equal to $3,500.

''(C) BENEFICIARIES WITH ANNUAL INCOMES BETWEEN 400 AND 600 PERCENT OF THE POVERTY LINE.—In the case of an eligible beneficiary whose income (as so determined) equals or exceeds 400 percent, but does not exceed 600 percent, of the poverty line, the annual out-of-pocket limit is equal to $5,500.

''(D) BENEFICIARIES WITH ANNUAL INCOMES THAT EXCEED 600 PERCENT OF THE POVERTY LINE.—In the case of an eligible beneficiary whose income (as so determined) equals or exceeds 600 percent of the poverty line, the annual out-of-pocket limit is an amount equal to 20 percent of that beneficiary's income for that year (rounded to the nearest multiple of $1).

''(3) APPLICATION.—In applying paragraph (2), incurred costs shall only include those expenses for covered drugs that are incurred by the eligible beneficiary using a card approved by the Secretary under this part that are paid by that beneficiary and for which the beneficiary is not reimbursed (through insurance or otherwise) by another person.

''(4) ANNUAL PERCENTAGE INCREASE.—

''(A) IN GENERAL.—In the case of any calendar year after 2006, the dollar amounts in subparagraphs (A), (B), and (C) of paragraph (2) shall be increased by an amount equal to—

''(i) such dollar amount; multiplied by

''(ii) the inflation adjustment determined under section 1860E(a)(2)(B) for such calendar year.

''(B) ROUNDING.—If any increase determined under subparagraph (A) is not a multiple of $1, such increase shall be rounded to the nearest multiple of $1.

''(5) ELIGIBLE ENTITY NOT AT FINANCIAL RISK FOR CATASTROPHIC BENEFIT.—

''(A) IN GENERAL.—The Secretary, and not the eligible entity, shall be at financial risk for the provision of the catastrophic benefit under this subsection.

''(B) PROVISIONS RELATING TO PAYMENTS TO ELIGIBLE ENTITIES.—For provisions relating to payments to eligible entities for administering the catastrophic benefit under this subsection, see section 1860H.

''(6) ENSURING CATASTROPHIC BENEFIT IN ALL AREAS.—The Secretary shall develop procedures for the provision of the catastrophic benefit under this subsection to each eligible beneficiary that resides in an area where there are no prescription drug discount card plans offered that have been awarded a contract under this part.

''REQUIREMENTS FOR ENTITIES TO PROVIDE PRESCRIPTION DRUG COVERAGE

''SEC. 1860G. (a) ESTABLISHMENT OF BIDDING PROCESS.—The Secretary shall establish a process under which the Secretary accepts bids from eligible entities and awards contracts to the entities to provide the benefits

under this part to eligible beneficiaries in an area.

''(b) SUBMISSION OF BIDS.—Each eligible entity desiring to enter into a contract under this part shall submit a bid to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may require.

''(c) ADMINISTRATIVE FEE BID.—

''(1) SUBMISSION.—For the bid described in subsection (b), each entity shall submit to the Secretary information regarding administration of the discount card and catastrophic benefit under this part.

''(2) BID SUBMISSION REQUIREMENTS.—

''(A) ADMINISTRATIVE FEE BID SUBMISSION.—In submitting bids, the entities shall include separate costs for administering the discount card component, if applicable, and the catastrophic benefit. The entity shall submit the administrative fee bid in a form and manner specified by the Secretary, and shall include a statement of projected enrollment and a separate statement of the projected administrative costs for at least the following functions:

''(i) Enrollment, including income eligibility determination.

''(ii) Claims processing.

''(iii) Quality assurance, including drug utilization review.

''(iv) Beneficiary and pharmacy customer service.

''(v) Coordination of benefits.

''(vi) Fraud and abuse prevention.

''(B) NEGOTIATED ADMINISTRATIVE FEE BID AMOUNTS.—The Secretary has the authority to negotiate regarding the bid amounts submitted. The Secretary may reject a bid if the Secretary determines it is not supported by the administrative cost information provided in the bid as specified in subparagraph (A).

''(C) PAYMENT TO PLANS BASED ON ADMINISTRATIVE FEE BID AMOUNTS.—The Secretary shall use the bid amounts to calculate a benchmark amount consisting of the enrollment-weighted average of all bids for each function and each class of entity. The class of entity is either a regional or national entity, or such other classes as the Secretary may determine to be appropriate. The functions are the discount card and catastrophic components. If an eligible entity's combined bid for both functions is above the combined benchmark within the entity's class for the functions, the eligible entity shall collect additional necessary revenue through 1 or both of the following:

''(i) Additional fees charged to the beneficiary, not to exceed $25 annually.

''(ii) Use of rebate amounts from drug manufacturers to defray administrative costs.

''(d) AWARDING OF CONTRACTS.—

''(1) IN GENERAL.—The Secretary shall, consistent with the requirements of this part and the goal of containing medicare program costs, award at least 2 contracts in each area, unless only 1 bidding entity meets the terms and conditions specified by the Secretary under paragraph (2).

''(2) TERMS AND CONDITIONS.—The Secretary shall not award a contract to an eligible entity under this section unless the Secretary finds that the eligible entity is in compliance with such terms and conditions as the Secretary shall specify.

''(3) REQUIREMENTS FOR ELIGIBLE ENTITIES PROVIDING DISCOUNT CARD PROGRAM.—Except as provided in subsection (e), in determining which of the eligible entities that submitted bids that meet the terms and conditions specified by the Secretary under paragraph (2) to award a contract, the Secretary shall consider whether the bid submitted by the entity meets at least the following requirements:

''(A) LEVEL OF SAVINGS TO MEDICARE BENEFICIARIES.—The program passes on to medicare beneficiaries who enroll in the program discounts on prescription drugs, including discounts negotiated with manufacturers.

''(B) PROHIBITION ON APPLICATION ONLY TO MAIL ORDER.—The program applies to drugs that are available other than solely through mail order and provides convenient access to retail pharmacies.

''(C) LEVEL OF BENEFICIARY SERVICES.—The program provides pharmaceutical support services, such as education and services to prevent adverse drug interactions.

''(D) ADEQUACY OF INFORMATION.—The program makes available to medicare beneficiaries through the Internet and otherwise information, including information on enrollment fees, prices charged to beneficiaries, and services offered under the program, that the Secretary identifies as being necessary to provide for informed choice by beneficiaries among endorsed programs.

''(E) EXTENT OF DEMONSTRATED EXPERIENCE.—The entity operating the program has demonstrated experience and expertise in operating such a program or a similar program.

''(F) EXTENT OF QUALITY ASSURANCE.—The entity has in place adequate procedures for assuring quality service under the program.

''(G) OPERATION OF ASSISTANCE PROGRAM.—The entity meets such requirements relating to solvency, compliance with financial reporting requirements, audit compliance, and contractual guarantees as specified by the Secretary.

''(H) PRIVACY COMPLIANCE.—The entity implements policies and procedures to safeguard the use and disclosure of program beneficiaries' individually identifiable health information in a manner consistent with the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

''(I) ADDITIONAL BENEFICIARY PROTECTIONS.—The program meets such additional requirements as the Secretary identifies to protect and promote the interest of medicare beneficiaries, including requirements that ensure that beneficiaries are not charged more than the lower of the negotiated retail price or the usual and customary price.

The prices negotiated by a prescription drug discount card program endorsed under this section shall (notwithstanding any other provision of law) not be taken into account for the purposes of establishing the best price under section 1927(c)(1)(C).

''(4) BENEFICIARY ACCESS TO SAVINGS AND REBATES.—The Secretary shall require eligible entities offering a discount card program to pass on savings and rebates negotiated with manufacturers to eligible beneficiaries enrolled with the entity.

''(5) NEGOTIATED AGREEMENTS WITH EMPLOYER-SPONSORED PLANS.—Notwithstanding any other provision of this part, the Secretary may negotiate agreements with employer-sponsored plans under which eligible beneficiaries are provided with a benefit for prescription drug coverage that is more generous than the benefit that would otherwise have been available under this part if such an agreement results in cost savings to the Federal Government.

''(e) REQUIREMENTS FOR OTHER ELIGIBLE ENTITIES.—An eligible entity that is licensed under State law to provide the health insurance benefits under this section shall be required to meet the requirements of subsection (d)(3). If an eligible entity offers a national plan, such entity shall not be required to meet the requirements of subsection (d)(3), but shall meet the requirements of Employee Retirement Income Security Act of 1974 that apply with respect to such plan.

''PAYMENTS TO ELIGIBLE ENTITIES FOR ADMINISTERING THE CATASTROPHIC BENEFIT

''SEC. 1860H. (a) IN GENERAL.—The Secretary may establish procedures for making payments to an eligible entity under a contract entered into under this part for—

''(1) the costs of providing covered drugs to beneficiaries eligible for the benefit under this part in accordance with subsection (b) minus the amount of any cost-sharing collected by the eligible entity under section 1860F(b); and

''(2) costs incurred by the entity in administering the catastrophic benefit in accordance with section 1860G.

''(b) PAYMENT FOR COVERED DRUGS.—

''(1) IN GENERAL.—Except as provided in subsection (c) and subject to paragraph (2), the Secretary may only pay an eligible entity for covered drugs furnished by the eligible entity to an eligible beneficiary enrolled with such entity under this part that is eligible for the catastrophic benefit under section 1860F(b).

''(2) LIMITATIONS.—

''(A) FORMULARY RESTRICTIONS.—Insofar as an eligible entity with a contract under this part uses a formulary, the Secretary may not make any payment for a covered drug that is not included in such formulary, except to the extent provided under section 1860D(a)(4)(B).

''(B) NEGOTIATED PRICES.—The Secretary may not pay an amount for a covered drug furnished to an eligible beneficiary that exceeds the negotiated price (including applicable discounts) that the beneficiary would have been responsible for under section 1860F(a) or the price negotiated for insurance coverage under the Medicare+Choice program under part C, a medicare supplemental policy, employer-sponsored coverage, or a State plan.

''(C) COST-SHARING LIMITATIONS.—An eligible entity may not charge an individual enrolled with such entity who is eligible for the catastrophic benefit under this part any copayment, tiered copayment, coinsurance, or other cost-sharing that exceeds 10 percent of the cost of the drug that is dispensed to the individual.

''(3) PAYMENT IN COMPETITIVE AREAS.—In a geographic area in which 2 or more eligible entities offer a plan under this part, the Secretary may negotiate an agreement with the entity to reimburse the entity for costs incurred in providing the benefit under this part on a capitated basis.

''(c) SECONDARY PAYER PROVISIONS.—The provisions of section 1862(b) shall apply to the benefits provided under this part.

''DETERMINATION OF INCOME LEVELS

''SEC. 1860I. (a) DETERMINATION OF INCOME LEVELS.—

''(1) IN GENERAL.—The Secretary shall establish procedures under which each eligible entity awarded a contract under this part determines the income levels of eligible beneficiaries enrolled in a prescription drug card plan offered by that entity at least annually for purposes of sections 1860E(c) and 1860F(b).

''(2) PROCEDURES.—The procedures established under paragraph (1) shall require each eligible beneficiary to submit such information as the eligible entity requires to make the determination described in paragraph (1).

''(b) ENFORCEMENT OF INCOME DETERMINATIONS.—The Secretary shall—

''(1) establish procedures that ensure that eligible beneficiaries comply with sections 1860E(c) and 1860F(b); and

''(2) require, if the Secretary determines that payments were made under this part to which an eligible beneficiary was not entitled, the repayment of any excess payments with interest and a penalty.

''(c) QUALITY CONTROL SYSTEM.—

''(1) ESTABLISHMENT.—The Secretary shall establish a quality control system to monitor income determinations made by eligible entities under this section and to produce appropriate and comprehensive measures of error rates.

''(2) PERIODIC AUDITS.—The Inspector General of the Department of Health and Human Services shall conduct periodic audits to ensure that the system established under paragraph (1) is functioning appropriately.

''APPROPRIATIONS

''SEC. 1860J. There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Federal Supplementary Medical Insurance Trust Fund established under section 1841, an amount equal to the amount by which the benefits and administrative costs of providing the benefits under this part exceed the enrollment fees collected under section 1860E.

''MEDICARE COMPETITION AND PRESCRIPTION DRUG ADVISORY BOARD

''SEC. 1860K. (a) ESTABLISHMENT OF BOARD.—There is established a Medicare Prescription Drug Advisory Board (in this section referred to as the 'Board').

''(b) ADVICE ON POLICIES; REPORTS.—

''(1) ADVICE ON POLICIES.—The Board shall advise the Secretary on policies relating to the Voluntary Medicare Prescription Drug Discount and Security Program under this part.

''(2) REPORTS.—

''(A) IN GENERAL.—With respect to matters of the administration of the program under this part, the Board shall submit to Congress and to the Secretary such reports as the Board determines appropriate. Each such report may contain such recommendations as the Board determines appropriate for legislative or administrative changes to improve the administration of the program under this part. Each such report shall be published in the Federal Register.

''(B) MAINTAINING INDEPENDENCE OF BOARD.—The Board shall directly submit to Congress reports required under subparagraph (A). No officer or agency of the United States may require the Board to submit to any officer or agency of the United States for approval, comments, or review, prior to the submission to Congress of such reports.

''(c) STRUCTURE AND MEMBERSHIP OF THE BOARD.—

''(1) MEMBERSHIP.—The Board shall be composed of 7 members who shall be appointed as follows:

''(A) PRESIDENTIAL APPOINTMENTS.—

''(i) IN GENERAL.—Three members shall be appointed by the President, by and with the advice and consent of the Senate.

''(ii) LIMITATION.—Not more than 2 such members may be from the same political party.

''(B) SENATORIAL APPOINTMENTS.—Two members (each member from a different political party) shall be appointed by the President pro tempore of the Senate with the advice of the Chairman and the Ranking Minority Member of the Committee on Finance of the Senate.

''(C) CONGRESSIONAL APPOINTMENTS.—Two members (each member from a different political party) shall be appointed by the Speaker of the House of Representatives, with the advice of the Chairman and the Ranking Minority Member of the Committee on Ways and Means of the House of Representatives.

''(2) QUALIFICATIONS.—The members shall be chosen on the basis of their integrity, impartiality, and good judgment, and shall be individuals who are, by reason of their education, experience, and attainments, exceptionally qualified to perform the duties of members of the Board.

''(3) COMPOSITION.—Of the members appointed under paragraph (1)—

''(A) at least 1 shall represent the pharmaceutical industry;

''(B) at least 1 shall represent physicians;

''(C) at least 1 shall represent medicare beneficiaries;

''(D) at least 1 shall represent practicing pharmacists; and

''(E) at least 1 shall represent eligible entities.

''(d) TERMS OF APPOINTMENT.—

''(1) IN GENERAL.—Subject to paragraph (2), each member of the Board shall serve for a term of 6 years.

''(2) CONTINUANCE IN OFFICE AND STAGGERED TERMS.—

''(A) CONTINUANCE IN OFFICE.—A member appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

''(B) STAGGERED TERMS.—The terms of service of the members initially appointed under this section shall begin on January 1, 2006, and expire as follows:

''(i) PRESIDENTIAL APPOINTMENTS.—The terms of service of the members initially appointed by the President shall expire as designated by the President at the time of nomination, 1 each at the end of—

''(I) 2 years;

''(II) 4 years; and

''(III) 6 years.

''(ii) SENATORIAL APPOINTMENTS.—The terms of service of members initially appointed by the President pro tempore of the Senate shall expire as designated by the President pro tempore of the Senate at the time of nomination, 1 each at the end of—

''(I) 3 years; and

''(II) 6 years.

''(iii) CONGRESSIONAL APPOINTMENTS.—The terms of service of members initially appointed by the Speaker of the House of Representatives shall expire as designated by the Speaker of the House of Representatives at the time of nomination, 1 each at the end of—

''(I) 4 years; and

''(II) 5 years.

''(C) REAPPOINTMENTS.—Any person appointed as a member of the Board may not serve for more than 8 years.

''(D) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Board shall be filled in the manner in which the original appointment was made.

''(e) CHAIRPERSON.—A member of the Board shall be designated by the President to serve as Chairperson for a term of 4 years or, if the remainder of such member's term is less than 4 years, for such remainder.

''(f) EXPENSES AND PER DIEM.—Members of the Board shall serve without compensation, except that, while serving on business of the Board away from their homes or regular places of business, members may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government employed intermittently.

''(g) MEETINGS.—

''(1) IN GENERAL.—The Board shall meet at the call of the Chairperson (in consultation with the other members of the Board) not less than 4 times each year to consider a specific agenda of issues, as determined by the Chairperson in consultation with the other members of the Board.

''(2) QUORUM.—Four members of the Board (not more than 3 of whom may be of the same political party) shall constitute a quorum for purposes of conducting business.

''(h) FEDERAL ADVISORY COMMITTEE ACT.—The Board shall be exempt from the provisions of the Federal Advisory Committee Act (5 U.S.C. App.).

''(i) PERSONNEL.—

''(1) STAFF DIRECTOR.—The Board shall, without regard to the provisions of title 5, United States Code, relating to the competitive service, appoint a Staff Director who shall be paid at a rate equivalent to a rate established for the Senior Executive Service under section 5382 of title 5, United States Code.

''(2) STAFF.—

''(A) IN GENERAL.—The Board may employ, without regard to chapter 31 of title 5, United States Code, such officers and employees as are necessary to administer the activities to be carried out by the Board.

''(B) FLEXIBILITY WITH RESPECT TO CIVIL SERVICE LAWS.—

''(i) IN GENERAL.—The staff of the Board shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and, subject to clause (ii), shall be paid without regard to the provisions of chapters 51 and 53 of such title (relating to classification and schedule pay rates).

''(ii) MAXIMUM RATE.—In no case may the rate of compensation determined under clause (i) exceed the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

''(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, out of the Federal Supplemental Medical Insurance Trust Fund established under section 1841, and the general fund of the Treasury, such sums as are necessary to carry out the purposes of this section.''.

(b) CONFORMING REFERENCES TO PREVIOUS PART D.—

(1) IN GENERAL.—Any reference in law (in effect before the date of enactment of this Act) to part D of title XVIII of the Social Security Act is deemed a reference to part E of such title (as in effect after such date).

(2) SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 6 months after the date of enactment of this section, the Secretary of Health and Human Services shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this section.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendment made by subsection (a) shall take effect on the date of enactment of this Act.

(2) IMPLEMENTATION.—Notwithstanding any provision of part D of title XVIII of the Social Security Act (as added by subsection (a)), the Secretary of Health and Human Services shall implement the Voluntary Medicare Prescription Drug Discount and Security Program established under such part in a manner such that—

(A) benefits under such part for eligible beneficiaries (as defined in section 1860 of such Act, as added by such subsection) with annual incomes below 200 percent of the poverty line (as defined in such section) are available to such beneficiaries not later than the date that is 6 months after the date of enactment of this Act; and

(B) benefits under such part for other eligible beneficiaries are available to such beneficiaries not later than the date that is 1 year after the date of enactment of this Act.

SEC. 102. ADMINISTRATION OF VOLUNTARY MEDICARE PRESCRIPTION DRUG DISCOUNT AND SECURITY PROGRAM.

(a) ESTABLISHMENT OF CENTER FOR MEDICARE PRESCRIPTION DRUGS.—There is established, within the Centers for Medicare & Medicaid Services of the Department of Health and Human Services, a Center for Medicare Prescription Drugs. Such Center shall be separate from the Center for Beneficiary Choices, the Center for Medicare Management, and the Center for Medicaid and State Operations.

(b) DUTIES.—It shall be the duty of the Center for Medicare Prescription Drugs to administer the Voluntary Medicare Prescription Drug Discount and Security Program established under part D of title XVIII of the Social Security Act (as added by section 101).

(c) DIRECTOR.—

(1) APPOINTMENT.—There shall be in the Center for Medicare Prescription Drugs a Director of Medicare Prescription Drugs, who shall be appointed by the President, by and with the advice and consent of the Senate.

(2) RESPONSIBILITIES.—The Director shall be responsible for the exercise of all powers and the discharge of all duties of the Center for Medicare Prescription Drugs and shall have authority and control over all personnel and activities thereof.

(d) PERSONNEL.—The Director of the Center for Medicare Prescription Drugs may appoint and terminate such personnel as may be necessary to enable the Center for Medicare Prescription Drugs to perform its duties.

SEC. 103. EXCLUSION OF PART D COSTS FROM DETERMINATION OF PART B MONTHLY PREMIUM.

Section 1839(g) of the Social Security Act (42 U.S.C. 1395r(g)) is amended—

(1) by striking ''attributable to the application of section'' and inserting ''attributable to—

''(1) the application of section'';

(2) by striking the period and inserting ''; and''; and

(3) by adding at the end the following new paragraph:

''(2) the Voluntary Medicare Prescription Drug Discount and Security Program under part D.''.

SEC. 104. MEDIGAP REVISIONS.

Section 1882 of the Social Security Act (42 U.S.C. 1395ss) is amended by adding at the end the following new subsection:

''(v) MODERNIZATION OF MEDICARE SUPPLEMENTAL POLICIES.—

''(1) PROMULGATION OF MODEL REGULATION.—

''(A) NAIC MODEL REGULATION.—If, within 9 months after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, the National Association of Insurance Commissioners (in this subsection referred to as the 'NAIC') changes the 1991 NAIC Model Regulation (described in subsection (p)) to revise the benefit package classified as 'J' under the standards established by subsection (p)(2) (including the benefit package classified as 'J' with a high deductible feature, as described in subsection (p)(11)) so that—

''(i) the coverage for prescription drugs available under such benefit package is replaced with coverage for prescription drugs that complements but does not duplicate the benefits for prescription drugs that beneficiaries are otherwise entitled to under this title;

''(ii) a uniform format is used in the policy with respect to such revised benefits; and

''(iii) such revised standards meet any additional requirements imposed by the Prescription Drug and Medicare Improvement Act of 2003;

subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policy holders on and after January 1, 2006, as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation as changed under this subparagraph (such changed regulation referred to in this section as the '2006 NAIC Model Regulation').

''(B) REGULATION BY THE SECRETARY.—If the NAIC does not make the changes in the 1991 NAIC Model Regulation within the 9-month period specified in subparagraph (A), the Secretary shall promulgate, not later than 9 months after the end of such period, a regulation and subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policy holders on and after January 1, 2006, as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation as changed by the Secretary under this subparagraph (such changed regulation referred to in this section as the '2006 Federal Regulation').

''(C) CONSULTATION WITH WORKING GROUP.—In promulgating standards under this paragraph, the NAIC or Secretary shall consult with a working group similar to the working group described in subsection (p)(1)(D).

''(D) MODIFICATION OF STANDARDS IF MEDICARE BENEFITS CHANGE.—If benefits under part D of this title are changed and the Secretary determines, in consultation with the NAIC, that changes in the 2006 NAIC Model Regulation or 2006 Federal Regulation are needed to reflect such changes, the preceding provisions of this paragraph shall apply to the modification of standards previously established in the same manner as they applied to the original establishment of such standards.

''(2) CONSTRUCTION OF BENEFITS IN OTHER MEDICARE SUPPLEMENTAL POLICIES.—Nothing in the benefit packages classified as 'A' through 'I' under the standards established by subsection (p)(2) (including the benefit package classified as 'F' with a high deductible feature, as described in subsection (p)(11)) shall be construed as providing coverage for benefits for which payment may be made under part D.

''(3) APPLICATION OF PROVISIONS AND CONFORMING REFERENCES.—

''(A) APPLICATION OF PROVISIONS.—The provisions of paragraphs (4) through (10) of subsection (p) shall apply under this section, except that—

''(i) any reference to the model regulation applicable under that subsection shall be deemed to be a reference to the applicable 2006 NAIC Model Regulation or 2006 Federal Regulation; and

''(ii) any reference to a date under such paragraphs of subsection (p) shall be deemed to be a reference to the appropriate date under this subsection.

''(B) OTHER REFERENCES.—Any reference to a provision of subsection (p) or a date applicable under such subsection shall also be considered to be a reference to the appropriate provision or date under this subsection.''.

SA 1027. Ms. SNOWE submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, insert the following:

SEC. ___. SENSE OF THE SENATE REGARDING IMPLEMENTATION OF THE PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003.

(a) IN GENERAL.—It is the sense of the Senate that the Committee on Finance of the Senate should hold not less than 4 hearings to monitor implementation of the Prescription Drug and Medicare Improvement Act of 2003 (hereinafter in this section referred to as the ''Act'') during which the Secretary or his designee should testify before the Committee.

(b) INITIAL HEARING.—It is the sense of the Senate that the first hearing described in subsection (a) should be held not later than 60 days after the date of the enactment the Act. At the hearing, the Secretary or his designee should submit written testimony and testify before the Committee on Finance of the Senate on the following issues:

(1) The progress toward implementation of the prescription drug discount card under section 111 of the Act.

(2) Development of the blueprint that will direct the implementation of the provisions of the Act, including the implementation of title I (Medicare Prescription Drug Benefit), title II (MedicareAdvantage), and title III (Center for Medicare Choices) of the Act.

(3) Any problems that will impede the timely implementation of the Act.

(4) The overall progress toward implementation of the Act.

(c) SUBSEQUENT HEARINGS.—It is the sense of the Senate that the additional hearings described in subsection (a) should be held in each of May 2004, October 2004, and May 2005. At each hearing, the Secretary or his designee should submit written testimony and testify before the Committee on Finance of the Senate on the following issues:

(1) Progress on implementation of title I (Medicare Prescription Drug Benefit), title II (MedicareAdvantage), and title III (Center for Medicare Choices) of the Act.

(2) Any problems that will impede timely implementation of the Act.

SA 1028. Mr. CRAIG submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle A of title II, add the following:

SEC. ___. ESTABLISHMENT OF MEDICAREADVANTAGE CONSUMER-DRIVEN HEALTH PLAN OPTION.

(a) PROGRAM SPECIFICATIONS.—Part C of title XVIII (42 U.S.C. 1395w–21 et seq.), amended by section 205, is amended by inserting after section 1858A the following new section:

''CONSUMER-DRIVEN HEALTH PLAN OPTION

''SEC. 1858B. (a) ESTABLISHMENT OF PROGRAM.—

''(1) IN GENERAL.—Beginning on January 1, 2006, there is established a consumer-driven health plan program under which consumer-driven health plans offered by consumer-driven health plan sponsors are offered to MedicareAdvantage eligible individuals in preferred provider regions.

''(2) DEFINITIONS.—

''(A) CONSUMER-DRIVEN HEALTH PLAN SPONSOR.—The term 'consumer-driven health plan sponsor' means an entity with a contract under section 1857 that meets the requirements of this section applicable with respect to consumer-driven health plan sponsors.

''(B) CONSUMER-DRIVEN HEALTH PLAN.—The term 'consumer-driven health plan' means a MedicareAdvantage plan that—

''(i) provides 100 percent coverage for preventive benefits (as defined by the Secretary);

''(ii) includes a personal care account from which enrollees must pay out-of-pocket costs until the deductible is met; and

''(iii) has a high deductible (as determined by the Secretary).

''(C) PREFERRED PROVIDER REGION.—The term 'preferred provider region' has the meaning given that term under section 1858(a)(2)(C).

''(b) ELIGIBILITY, ELECTION, AND ENROLLMENT; BENEFITS AND BENEFICIARY PROTECTIONS.—

''(1) IN GENERAL.—Except as provided in the succeeding provisions of this subsection, the provisions of sections 1851 and 1852 that apply with respect to coordinated care plans shall apply to consumer-driven health plans offered by a consumer-driven health plan sponsor.

''(2) SERVICE AREA.—The service area of a consumer-driven health plan shall be a preferred provider region.

''(3) AVAILABILITY.—Each consumer-driven health plan must be offered to each MedicareAdvantage eligible individual who resides in the service area of the plan.

''(4) AUTHORITY TO PROHIBIT RISK SELECTION.—The provisions of section 1852(a)(6) shall apply to preferred provider organization plans.

''(5) ASSURING ACCESS TO SERVICES IN CONSUMER-DRIVEN HEALTH PLANS.—The requirements of section 1858(a)(5) shall apply to consumer-driven health plans.

''(6) PERSONAL CARE ACCOUNTS.—

''(A) ESTABLISHMENT.—Each consumer-driven health plan shall establish a personal care account on behalf of each enrollee from which such enrollee shall be required to pay out-of-pockets costs until the deductible described in subsection (a)(2)(B)(iii) is met.

''(B) ROLLOVER.—Subject to subparagraph (C), any amounts remaining in a personal care account at the end of a year shall be credited to such an account for the subsequent year.

''(C) CHANGES OF ELECTION.—If, after electing a consumer-driven health plan, a beneficiary elects a plan under this part that is not a consumer-driven health plan during a subsequent year or elects to receive benefits under the original medicare fee-for-service program option (whether or not as a result of circumstances described in section 1851(e)(4)), any amounts remaining in the account as of the date of such election shall be credited to the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841 in such proportion as the Secretary determines is appropriate.

''(c) PAYMENTS TO CONSUMER-DRIVEN HEALTH PLAN SPONSORS.—

''(1) PAYMENTS TO ORGANIZATIONS.—

''(A) MONTHLY PAYMENTS.—

''(i) IN GENERAL.—Under a contract under section 1857 and subject to paragraph (5), subsections (e) and (i), and section 1859(e)(4), the Secretary shall make, to each consumer-driven health plan sponsor, with respect to coverage of an individual for a month under this part in a preferred provider region, separate monthly payments with respect to—

''(I) benefits under the original medicare fee-for-service program under parts A and B in accordance with paragraph (4); and

''(II) benefits under the voluntary prescription drug program under part D in accordance with section 1858A and the other provisions of this part.

''(ii) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—The Secretary shall establish separate rates of payment applicable with respect to classes of individuals determined to have end-stage renal disease and enrolled in a consumer-driven health plan under this clause that are similar to the separate rates of payment described in section 1853(a)(1)(B).

''(B) ADJUSTMENT TO REFLECT NUMBER OF ENROLLEES.—The Secretary may retroactively adjust the amount of payment under this paragraph in a manner that is similar to the manner in which payment amounts may be retroactively adjusted under section 1853(a)(2).

''(C) COMPREHENSIVE RISK ADJUSTMENT METHODOLOGY.—The Secretary shall apply the comprehensive risk adjustment methodology described in section 1853(a)(3)(B) to 100 percent of the amount of payments to plans under paragraph (4)(D)(ii).

''(D) ADJUSTMENT FOR SPENDING VARIATIONS WITHIN A REGION.—The Secretary shall establish a methodology for adjusting the amount of payments to plans under paragraph (4)(D)(ii) that achieves the same objective as the adjustment described in paragraph 1853(a)(2)(C).

''(2) APPLICATION OF PREFERRED PROVIDER BENCHMARKS.—The benchmark amounts calculated under section 1858(c)(2) shall apply with respect to consumer-driven health plans.

''(3) APPLICATION OF PREFERRED PROVIDER PAYMENT FACTORS.—The provisions of section 1858(c)(3) shall apply with respect to consumer driven health plans.

''(4) SECRETARY'S DETERMINATION OF PAYMENT AMOUNT FOR BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM.—The Secretary shall determine the payment amount for plans as follows:

''(A) REVIEW OF PLAN BIDS.—The Secretary shall review each plan bid submitted under subsection (d)(1) for the coverage of benefits under the original medicare fee-for-service program option to ensure that such bids are consistent with the requirements under this part and are based on the assumptions described in section 1854(a)(2)(A)(iii).

''(B) DETERMINATION OF PREFERRED PROVIDER REGIONAL BENCHMARK AMOUNTS.—The preferred provider regional benchmark calculated under section 1858(c)(4)(B) shall apply with respect to consumer-drive health plans amount for that plan for the benefits under the original medicare fee-for-service program option for each plan equal to the regional benchmark adjusted by using the assumptions described in section 1854(a)(2)(A)(iii).

''(C) COMPARISON TO BENCHMARK.—The Secretary shall determine the difference between each plan bid (as adjusted under subparagraph (A)) and the preferred provider regional benchmark amount (as determined under subparagraph (B)) for purposes of determining—

''(i) the payment amount under subparagraph (D); and

''(ii) the additional benefits required and MedicareAdvantage monthly basic beneficiary premiums.

''(D) DETERMINATION OF PAYMENT AMOUNT.—

''(i) IN GENERAL.—Subject to clause (ii), the Secretary shall determine the payment amount to a consumer-driven health plan sponsor for a consumer-driven health plan as follows:

''(I) BIDS THAT EQUAL OR EXCEED THE BENCHMARK.—In the case of a plan bid that equals or exceeds the preferred provider regional benchmark amount, the amount of each monthly payment to the organization with respect to each individual enrolled in a plan shall be the preferred provider regional benchmark amount.

''(II) BIDS BELOW THE BENCHMARK.—In the case of a plan bid that is less than the preferred provider regional benchmark amount, the amount of each monthly payment to the organization with respect to each individual enrolled in a plan shall be the preferred provider regional benchmark amount reduced by the amount of any premium reduction elected by the plan under section 1854(d)(1)(A)(i).

''(ii) APPLICATION OF ADJUSTMENT METHODOLOGIES.—The Secretary shall adjust the amounts determined under subparagraph (A) using the factors described in section 1858(c)(3)(A)(ii).

''(E) FACTORS USED IN ADJUSTING BIDS AND BENCHMARKS FOR CONSUMER-DRIVEN HEALTH PLAN SPONSORS AND IN DETERMINING ENROLLEE PREMIUMS.—Subject to subparagraph (F), in addition to the factors used to adjust payments to plans described in section 1853(d)(6), the Secretary shall use the adjustment for geographic variation within the region established under paragraph (1)(D).

''(F) ADJUSTMENT FOR NATIONAL COVERAGE DETERMINATIONS AND LEGISLATIVE CHANGES IN BENEFITS.—The Secretary shall provide for adjustments for national coverage determinations and legislative changes in benefits applicable with respect to consumer-driven health plan sponsors in the same manner as the Secretary provides for adjustments under section 1853(d)(7).

''(5) PAYMENTS FROM TRUST FUND.—The payment to a consumer-driven health plan sponsor under this section shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in a manner similar to the manner described in section 1853(g).

''(6) SPECIAL RULE FOR CERTAIN INPATIENT HOSPITAL STAYS.—Rules similar to the rules applicable under section 1853(h) shall apply with respect consumer-driven health plan sponsors.

''(7) SPECIAL RULE FOR HOSPICE CARE.—Rules similar to the rules applicable under section 1853(i) shall apply with respect to consumer-driven health plan sponsors.

''(d) SUBMISSION OF BIDS BY CONSUMER-DRIVEN HEALTH PLANS; PREMIUMS.—

''(1) SUBMISSION OF BIDS BY CONSUMER-DRIVEN HEALTH PLAN SPONSORS.—

''(A) IN GENERAL.—For the requirements on submissions by consumer-driven health plans, see section 1854(a)(1).

''(B) UNIFORM PREMIUMS.—Each bid amount submitted under subparagraph (A) for a consumer-driven health plan in a preferred provider region may not vary among MedicareAdvantage eligible individuals residing in such preferred provider region.

''(C) APPLICATION OF FEHBP STANDARD; PROHIBITION ON PRICE GOUGING.—Each bid amount submitted under subparagraph (A) for a consumer-driven health plan must reasonably and equitably reflect the cost of benefits provided under that plan.

''(D) REVIEW.—The Secretary shall review the adjusted community rates (as defined in section 1854(g)(3)), the amounts of the MedicareAdvantage monthly basic premium and the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits filed under this paragraph and shall approve or disapprove such rates and amounts so submitted. The Secretary shall review the actuarial assumptions and data used by the consumer-driven health plan sponsor with respect to such rates and amounts so submitted to determine the appropriateness of such assumptions and data.

''(E) NO LIMIT ON NUMBER OF PLANS IN A REGION.—The Secretary may not limit the number of consumer-driven health plans offered in a preferred provider region.

''(2) MONTHLY PREMIUMS CHARGED.—The amount of the monthly premium charged to an individual enrolled in a consumer-driven health plan offered by a consumer-driven health plan sponsor shall be equal to the sum of the following:

''(A) The MedicareAdvantage monthly basic beneficiary premium, as defined in section 1854(b)(2)(A) (if any).

''(B) The MedicareAdvantage monthly beneficiary premium for enhanced medical benefits, as defined in section 1854(b)(2)(C) (if any).

''(C) The MedicareAdvantage monthly obligation for qualified prescription drug coverage, as defined in section 1854(b)(2)(B) (if any).

''(3) DETERMINATION OF PREMIUM REDUCTIONS, REDUCED COST-SHARING, ADDITIONAL BENEFITS, AND BENEFICIARY PREMIUMS.—The rules for determining premium reductions, reduced cost-sharing, additional benefits, and beneficiary premiums under section 1854(d) shall apply with respect to consumer-driven health plan sponsors.

''(4) PROHIBITION OF SEGMENTING PREFERRED PROVIDER REGIONS.—The Secretary may not permit a consumer-driven health plan sponsor to elect to apply the provisions of this section uniformly to separate segments of a preferred provider region (rather than uniformly to an entire preferred provider region).

''(e) PORTION OF TOTAL PAYMENTS TO AN ORGANIZATION SUBJECT TO RISK FOR 2 YEARS.—

''(1) NOTIFICATION OF SPENDING UNDER THE PLAN.—

''(A) IN GENERAL.—For 2007 and 2008, the consumer-driven health plan sponsor offering a consumer-driven health plan shall notify the Secretary of the total amount of costs that the organization incurred in providing benefits covered under parts A and B of the original medicare fee-for-service program for all enrollees under the plan in the previous year.

''(B) CERTAIN EXPENSES NOT INCLUDED.—The total amount of costs specified in subparagraph (A) may not include—

''(i) subject to subparagraph (C), administrative expenses incurred in providing the benefits described in such subparagraph; or

''(ii) amounts expended on providing enhanced medical benefits under section 1852(a)(3)(D).

''(C) ESTABLISHMENT OF ALLOWABLE ADMINISTRATIVE EXPENSES.—For purposes of applying subparagraph (B)(i), the administrative expenses incurred in providing benefits described in subparagraph (A) under a consumer-driven health plan may not exceed an amount determined appropriate by the Administrator.

''(2) ADJUSTMENT OF PAYMENT.—

''(A) NO ADJUSTMENT IF COSTS WITHIN RISK CORRIDOR.—If the total amount of costs specified in paragraph (1)(A) for the plan for the year are not more than the first threshold upper limit of the risk corridor (specified in paragraph (3)(A)(iii)) and are not less than the first threshold lower limit of the risk corridor (specified in paragraph (3)(A)(i)) for the plan for the year, then no additional payments shall be made by the Secretary and no reduced payments shall be made to the consumer-driven health plan sponsor offering the plan.

''(B) INCREASE IN PAYMENT IF COSTS ABOVE UPPER LIMIT OF RISK CORRIDOR.—

''(i) IN GENERAL.—If the total amount of costs specified in paragraph (1)(A) for the plan for the year are more than the first threshold upper limit of the risk corridor for the plan for the year, then the Secretary shall increase the total of the monthly payments made to the consumer-driven health plan sponsor offering the plan for the year under subsection (c)(1)(A) by an amount equal to the sum of—

''(I) 50 percent of the amount of such total costs which are more than such first threshold upper limit of the risk corridor and not more than the second threshold upper limit of the risk corridor for the plan for the year (as specified under paragraph (3)(A)(iv)); and

''(II) 10 percent of the amount of such total costs which are more than such second threshold upper limit of the risk corridor.

''(C) REDUCTION IN PAYMENT IF COSTS BELOW LOWER LIMIT OF RISK CORRIDOR.—If the total amount of costs specified in paragraph (1)(A) for the plan for the year are less than the first threshold lower limit of the risk corridor for the plan for the year, then the Secretary shall reduce the total of the monthly payments made to the consumer-driven health plan sponsor offering the plan for the year under subsection (c)(1)(A) by an amount (or otherwise recover from the plan an amount) equal to—

''(i) 50 percent of the amount of such total costs which are less than such first threshold lower limit of the risk corridor and not less than the second threshold lower limit of the risk corridor for the plan for the year (as specified under paragraph (3)(A)(ii)); and

''(ii) 10 percent of the amount of such total costs which are less than such second threshold lower limit of the risk corridor.

''(3) ESTABLISHMENT OF RISK CORRIDORS.—

''(A) IN GENERAL.—For 2006 and 2007, the Secretary shall establish a risk corridor for each consumer-driven health plan. The risk corridor for a plan for a year shall be equal to a range as follows:

''(i) FIRST THRESHOLD LOWER LIMIT.—The first threshold lower limit of such corridor shall be equal to—

''(I) the target amount described in subparagraph (B) for the plan; minus

''(II) an amount equal to 5 percent of such target amount.

''(ii) SECOND THRESHOLD LOWER LIMIT.—The second threshold lower limit of such corridor shall be equal to—

''(I) the target amount described in subparagraph (B) for the plan; minus

''(II) an amount equal to 10 percent of such target amount.

''(iii) FIRST THRESHOLD UPPER LIMIT.—The first threshold upper limit of such corridor shall be equal to the sum of—

''(I) such target amount; and

''(II) the amount described in clause (i)(II).

''(iv) SECOND THRESHOLD UPPER LIMIT.—The second threshold upper limit of such corridor shall be equal to the sum of—

''(I) such target amount; and

''(II) the amount described in clause (ii)(II).

''(B) TARGET AMOUNT DESCRIBED.—The target amount described in this paragraph is, with respect to a consumer-driven health plan offered by a consumer-driven health plan sponsor in a year, an amount equal to the sum of—

''(i) the total monthly payments made to the organization for enrollees in the plan for the year under subsection (c)(1)(A); and

''(ii) the total MedicareAdvantage basic beneficiary premiums collected for such enrollees for the year under subsection (d)(2)(A).

''(4) PLANS AT RISK FOR ENTIRE AMOUNT OF ENHANCED MEDICAL BENEFITS.—A consumer-driven health plan sponsor that offers a consumer-driven health plan that provides enhanced medial benefits under section 1852(a)(3)(D) shall be at full financial risk for the provision of such benefits.

''(5) NO EFFECT ON ELIGIBLE BENEFICIARIES.—No change in payments made by reason of this subsection shall affect the amount of the MedicareAdvantage basic beneficiary premium that a beneficiary is otherwise required to pay under the plan for the year under subsection (d)(2)(A).

''(6) DISCLOSURE OF INFORMATION.—The provisions of section 1860D–16(b)(7), including subparagraph (B) of such section, shall apply to a consumer-driven health plan sponsor and a consumer-driven health plan in the same manner as such provisions apply to an eligible entity and a Medicare Prescription Drug plan under part D.

''(f) ORGANIZATIONAL AND FINANCIAL REQUIREMENTS FOR CONSUMER-DRIVEN HEALTH PLAN SPONSORS.—A consumer-driven health plan sponsor shall be organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State within the preferred provider region in which it offers a consumer-driven health plan.

''(g) INAPPLICABILITY OF PROVIDER-SPONSORED ORGANIZATION SOLVENCY STANDARDS.—The requirements of section 1856 shall not apply with respect to consumer-driven health plan sponsors.

''(h) CONTRACTS WITH CONSUMER-DRIVEN HEALTH PLAN SPONSORS.—The provisions of section 1857 shall apply to a consumer-driven health plan offered by a consumer-driven health plan sponsor under this section.

''(i) BUDGET NEUTRALITY.—Notwithstanding any other provision of this section, in conducting the program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary under this title do not exceed the amount the Secretary would have paid if this section had not been enacted.''.

(b) CONSUMER-DRIVEN HEALTH PLAN TERMINOLOGY DEFINED.—Section 1859(a) (42 U.S.C. 1395w–29(a)), as amended by section 211(b), is amended by adding at the end the following new paragraph:

''(4) CONSUMER-DRIVEN HEALTH PLAN SPONSOR; CONSUMER-DRIVEN HEALTH PLAN.—The terms 'consumer-driven health plan sponsor' and 'consumer-driven health plan' have the meaning given such terms in section 1858B(a)(2).''.

SA 1029. Mr. SANTORUM submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, insert the following:

SEC. ___. MEDICARE COVERAGE OF CRITICAL ACCESS HEALTH CENTER SERVICES.

(a) IN GENERAL.—

(1) COVERAGE.—Section 1861(s)(2)(E) (42 U.S.C. 1395x(s)(2)(E)) is amended—

(A) by striking ''services and'' and inserting ''services,''; and

(B) by striking ''center services'' and inserting ''center services, and critical access health center services''.

(2) DEFINITIONS.—Section 1861(aa) (42 U.S.C. 1395x(aa)) is amended—

(A) in the heading—

(i) by striking ''Services and'' and inserting ''Services,''; and

(ii) by striking ''Center Services'' and inserting ''Center Services, and Critical Access Health Center Services'';

(B) in paragraph (1)(B), by striking ''paragraph (5)'' and inserting ''paragraph (7)'';

(C) by redesignating paragraphs (5), (6), and (7) as paragraphs (7), (8), and (9), respectively; and

(D) by inserting after paragraph (4) the following:

''(5) The term 'critical access health center services' means—

''(A) services of the type described in subparagraphs (A) through (C) of paragraph (1); and

''(B) preventive primary health services of the type that a health center is required to provide under section 330 of the Public Health Service Act,

when furnished to an individual who is an outpatient of a critical access health center and, for this purpose, any reference to a rural health clinic or a physician described in paragraph (2)(B) is deemed a reference to a critical access health center or a physician at the center, respectively.

''(6) The term 'critical access health center' means an entity that—

''(A) is sponsored by a private, nonprofit entity with a religious affiliation; and

''(B) based on the recommendation of the Centers for Medicare and Medicaid Services, is determined by the Secretary to meet the requirements for receiving a grant under section 330 of the Public Health Service Act (other than the requirement of subsection (n)(3)(H)(i) of such section).''.

(3) PAYMENTS.—

(A) SCOPE OF BENEFITS.—Section 1832(a) (42 U.S.C.1395k(a)) is amended—

(i) in paragraph (1), by striking ''subparagraphs (B) and (D)'' and inserting ''subparagraphs (B), (D), and (K)''; and

(ii) in paragraph (2)—

(I) by striking ''and'' at the end of subparagraph (I);

(II) by striking the period at the end of subparagraph (J) and inserting ''; and''; and

(III) by adding at the end the following:

''(K) critical access health center services.''.

(B) PAYMENT OF BENEFITS.—Section 1833(a) (42 U.S.C.1395*l*(a)) is amended—

(i) in the matter preceding subparagraph (A) of paragraph (2), by striking ''and (I)'' and inserting ''(I), and (K)''; and

(ii) in paragraph (3), by inserting ''or section 1832(a)(2)(K)'' after ''section 1832(a)(2)(D)''.

(C) PART B DEDUCTIBLE NOT APPLICABLE.—The first sentence of section 1833(b) (42 U.S.C. 1395*l*(b)) is amended by inserting ''or critical access health center services'' after ''Federally qualified health center services''.

(D) EXCEPTION TO EXCLUSIONS FROM COVERAGE.—Section 1862(a) of such Act (42 U.S.C. 1395y(a)) is amended—

(i) in paragraph (2), by inserting ''or critical access health center services (as defined in section 1861(aa)(5))'' after ''Federally qualified health center services'';

(ii) in paragraph (3), by inserting ''in the case of critical access health center services (as defined in section 1861(aa)(5)),'' after ''section 1880(e),''; and

(iii) in the second sentence, by inserting ''or critical access health center services described in section 1861(aa)(5)(B)'' after ''section 1861 (aa)(3)(B)''.

(E) EXCEPTION TO ANTI-KICKBACK LAW FOR WAIVER OF COINSURANCE.—Section 1128B(b)(3)(D) (42 U.S.C. 13206-7b(b)(3)(D)) is amended—

(i) by inserting ''(i)'' before ''a waiver'';

(ii) by inserting ''and'' after ''Act;''; and

(iii) by adding at the end the following:

''(ii) a waiver of—

''(I) any coinsurance under part B of title XVIII by a critical access health center with respect to an individual who qualifies for subsidized services under a provision of section 330 of the Public Health Service Act (as made applicable to such centers by section 1861(aa)(6)); and

''(II) the deductible and any coinsurance under such part by any provider of services, physician, or supplier to which such an individual is referred by a critical access health center for the provision of services that are not critical access health center services;''.

(F) CONFORMING AMENDMENTS.—

(i) Section 1842(b)(18)(C)(1) (42 U.S.C. 1395u(b)(18)(C)(1)) is amended by striking ''section 1861(aa)(5)'' and inserting ''section 1861(aa)(7)''.

(ii) Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended in subparagraph (H)(i), by striking ''subsection (aa)(5)'' and inserting ''subsection (aa)(7)''.

(iii) Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended in subparagraph (K)—

(I) by striking ''subsection (aa)(5)'' each place it appears and inserting ''subsection (aa)(7)''; and

(II) by striking ''subsection (aa)(6)'' and inserting ''subsection (aa)(8)''.

(b) EFFECTIVE DATE.—The amendments made this section shall apply to items and services furnished on or after October 1, 2004.

SEC. ___ . DEMONSTRATION TO IMPROVE ACCESS AND CONTINUITY OF CARE FOR LOW-INCOME BENEFICIARIES.

(a) IN GENERAL.—The Secretary shall—

(1) conduct a demonstration project to test the use of alternative payment methodologies to health care providers to improve access to ambulatory health care services and continuity of care for vulnerable populations such as low-income beneficiaries under title XVIII; and

(2) waive any provisions of the Social Security Act that are necessary to implement such demonstration.

(b) DURATION.—The demonstration project conducted pursuant to subsection (a) shall be for a term of at least 3 years and shall begin operation not later than 1 year after the date of the enactment of this Act.

(c) REPORTS.—

(1) INTERIM AND FINAL REPORTS REQUIRED.—The Secretary shall submit interim and final reports on the demonstration project conducted pursuant to subsection (a) to the Committee on Finance of the Senate and the Committee on Ways and Means and the Committee on Commerce of the House of Representatives. Such reports shall describe—

(A) the alternative payment methodologies in use under the demonstration;

(B) the provisions of law waived by the Secretary in order to conduct the demonstration; and

(C) the extent to which the demonstration has achieved the objectives described in subsection (a).

(2) TIMING OF REPORTS.—The Secretary shall submit the interim report required by paragraph (1) not later than 2 years after the commencement of the demonstration and the final report not later than 6 months after the termination the demonstration.

SA 1030. Mr. ENZI submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 356, strike lines 8 through 11, and insert the following:

''(C) CONSTRUCTION.—Subparagraph (B) shall not be construed as restricting—

''(i) the persons from whom enrollees under such plan may obtain covered benefits; or

''(ii) the categories of licensed health professionals or providers from whom enrollees under such a plan may obtain covered benefits if the covered services are provided to enrollees in a State where 25 percent or more of the population resides in health professional shortage areas designated pursuant to section 332 of the Public Health Service Act.''

SA 1031. Mr. CARPER submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle B of title IV, add the following:

SEC. ___. INCREASING TYPES OF ORIGINATING TELEHEALTH SITES AND FACILITATING THE PROVISION OF TELEHEALTH SERVICES ACROSS STATE LINES.

(a) INCREASING TYPES OF ORIGINATING SITES.—Section 1834(m)(4)(C)(ii) (42 U.S.C. 1395m(m)(4)(C)(ii)) is amended by adding at the end the following new subclauses:

''(VI) A skilled nursing facility (as defined in section 1819(a)).

''(VII) An assisted-living facility (as defined by the Secretary).

''(VIII) A board-and-care home (as defined by the Secretary).

''(IX) A county of community health clinic (as defined by the Secretary).

''(X) A community mental health center (as described in section 1861(ff)(2)(B)).

''(XI) A long-term care facility (as defined by the Secretary).

''(XII) A facility operated by the Indian Health Service or by an Indian tribe, tribal organization, or an urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)) directly, or under contract or other arrangement.''.

(b) FACILITATING THE PROVISION OF TELEHEALTH SERVICES ACROSS STATE LINES.—

(1) IN GENERAL.—For purposes of expediting the provision of telehealth services for which payment is made under the medicare program under section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)), across State lines, the Secretary shall, in consultation with representatives of States, physicians, health care practitioners, and patient advocates, encourage and facilitate the adoption of State provisions allowing for multistate practitioner licensure across State lines.

(2) DEFINITIONS.—In this subsection:

(A) TELEHEALTH SERVICE.—The term ''telehealth service'' has the meaning given that term in subparagraph (F)(i) of section 1834(m)(4) of the Social Security Act (42 U.S.C. 1395m(m)(4)).

(B) PHYSICIAN, PRACTITIONER.—The terms ''physician'' and ''practitioner'' have the meaning given those terms in subparagraphs (D) and (E), respectively, of such section.

(C) MEDICARE PROGRAM.—The term ''medicare program'' means the program of health insurance administered by the Secretary under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

SA 1032. Ms. MIKULSKI submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle A of title IV, add the following:

SEC. ___. PERMITTING DIRECT PAYMENT UNDER THE MEDICARE PROGRAM FOR CLINICAL SOCIAL WORKER SERVICES PROVIDED TO RESIDENTS OF SKILLED NURSING FACILITIES.

(a) IN GENERAL.—Section 1888(e)(2)(A)(ii) (42 U.S.C. 1395yy(e)(2)(A)(ii)) is amended by inserting ''clinical social worker services,'' after ''qualified psychologist services,''.

(b) CONFORMING AMENDMENT.—Section 1861(hh)(2) (42 U.S.C. 1395x(hh)(2)) is amended by striking ''and other than services furnished to an inpatient of a skilled nursing facility which the facility is required to provide as a requirement for participation''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after October 1, 2003.

SA 1033. Ms. MIKULSKI submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, add the following:

SEC. ___. EXTENSION OF MUNICIPAL HEALTH SERVICE DEMONSTRATION PROJECTS.

The last sentence of section 9215(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (42 U.S.C. 1395b–1 note), as previously amended, is amended by striking ''December 31, 2004, but only with respect to'' and all that follows and inserting ''December 31, 2009, but only with respect to individuals who reside in the city in which the project is operated and so long as the total number of individuals participating in the project does not exceed the number of such individuals participating as of January 1, 1996.''.

SA 1034. Ms. MIKULSKI submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle B of title IV, add the following:

SEC. ___. EQUITABLE TREATMENT FOR CHILDREN'S HOSPITALS.

(a) IN GENERAL.—Section 1833(t)(7)(D)(ii) (42 U.S.C. 1395l(t)(7)(D)(ii)) is amended to read as follows:

''(ii) PERMANENT TREATMENT FOR CANCER HOSPITALS AND CHILDREN'S HOSPITALS.—

''(I) CANCER HOSPITALS.—In the case of a hospital described in section 1886(d)(1)(B)(v), for covered OPD services for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount of such difference.

''(II) CHILDREN'S HOSPITALS.—In the case of a hospital described in section 1886(d)(1)(B)(iii), for covered OPD services furnished before October 1, 2003, and for which the PPS amount is less than the pre-BBA amount the amount of payment under this subsection shall be increased by the amount of such difference. In the case of such a hospital, for such services furnished on or after October 1, 2003, and for which the PPS amount is less than the greater of the pre-BBA amount or the reasonable operating and capital costs without reductions incurred in furnishing such services, the amount of payment under this subsection shall be increased by the amount of such difference.''.

SA 1035. Ms. MIKULSKI submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle B of title IV, add the following:

SEC. ___. EQUITABLE TREATMENT FOR CHILDREN'S HOSPITALS.

(a) IN GENERAL.—Section 1833(t)(7)(D)(ii) (42 U.S.C. 1395l(t)(7)(D)(ii)) is amended to read as follows:

''(ii) PERMANENT TREATMENT FOR CANCER HOSPITALS AND CHILDREN'S HOSPITALS.—

''(I) IN GENERAL.—Subject to subclause (II), in the case of a hospital described in clause (iii) or (v) of section 1886(d)(1)(B), for covered OPD services for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount of such difference.

''(II) SPECIAL RULE FOR CERTAIN CHILDREN'S HOSPITALS.—In the case of a hospital described in section 1886(d)(1)(B)(iii) that is located in a State with a reimbursement system under section 1814(b)(3), but that is not reimbursed under such system, for covered OPD services furnished on or after October 1, 2003, and for which the PPS amount is less than the greater of the pre-BBA amount or the reasonable operating and capital costs without reductions of the hospital in providing such services, the amount of payment under this subsection shall be increased by the amount of such difference.''.

SA 1036. Mr. REID (for Mrs. BOXER) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

On page 53, between line 8 and 9, insert the following:

''(6) NO COVERAGE GAP FOR ELIGIBLE BENEFICIARIES WITH CANCER.—

''(A) IN GENERAL.—In the case of an eligible beneficiary with cancer, the following rules shall apply:

''(i) Paragraph (2) shall be applied by substituting 'up to the annual out-of-pocket limit under paragraph (4)' for 'up to the initial coverage limit under paragraph (3)'.

''(ii) The Administrator shall not apply paragraph (3), subsection (d)(1)(C), or paragraph (1)(D), (2)(D), or (3)(A)(iv) of section 1860D–19(a).

''(B) PROCEDURES.—The Administrator shall establish procedures to carry out this paragraph. Such procedures shall provide for the adjustment of payments to eligible entities under section 1860D–16 that are necessary because of the rules under subparagraph (A).''

SA 1037. Mr. REID (for Mr. CORZINE) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end of subtitle A of title I, add the following:

SEC. ___. CONFORMING CHANGES REGARDING FEDERALLY QUALIFIED HEALTH CENTERS.

(a) PERMITTING FQHCS TO FILL PRESCRIPTIONS.—Section 1861(aa)(3) (42 U.S.C. 1395x(aa)(3)) is amended—

(1) in subparagraph (A), by striking ''and'' after the comma at the end;

(2) in subparagraph (B), by inserting ''and'' after the comma at the end; and

(3) by adding at the end the following new subparagraph:

''(C) drugs and biologicals for which payment may otherwise be made under this title,''.

(b) ELIMINATION OF PER VISIT LIMIT.—Section 1833(a)(3) (42 U.S.C. 1395l(a)(3)) is amended by inserting '', except that such regulations may not limit the per visit payment amount with regard to drugs and biologicals described in section 1861(aa)(3)(C)'' after ''the Secretary may prescribe in regulations''.

SA 1038. Mr. REID (for Mr. JEFFORDS) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end of section 405 add the following:

(g) EXCLUSION OF CERTAIN BEDS FROM BED COUNT AND REMOVAL OF BARRIERS TO ESTABLISHMENT OF DISTINCT PART UNITS.—

(1) EXCLUSION OF CERTAIN BEDS FROM BED COUNT.—Section 1820(c)(2) (42 U.S.C. 1395i-4(c)(2)) is amended by adding at the end the following:

''(E) EXCLUSION OF CERTAIN BEDS FROM BED COUNT.—In determining the number of beds of a facility for purposes of applying the bed limitations referred to in subparagraph (B)(iii) and subsection (f), the Secretary shall not take into account any bed of a distinct part psychiatric or rehabilitation unit (described in the matter following clause (v) of section 1886(d)(1)(B)) of the facility, except that the total number of beds that are not taken into account pursuant to this subparagraph with respect to a facility shall not exceed 25.''.

(2) REMOVING BARRIERS TO ESTABLISHMENT OF DISTINCT PART UNITS BY CRITICAL ACCESS HOSPITALS.—Section 1886(d)(1)(B) (42 U.S.C. 195ww(d)(1)(B)) is amended by striking ''a distinct part of the hospital (as defined by the Secretary)'' in the matter following cause (v) and inserting ''a distinct part (as defined by the Secretary) of the hospital or of a critical access hospital''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to determinations with respect to distinct part unit status, and with respect to designations, that are made on or after October 1, 2003.

SA 1039. Mr. REID (for Mr. INOUYE) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the appropriate place, insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Native Hawaiian Medicaid Coverage Act of 2003''.

SEC. 2. 100 PERCENT FMAP FOR MEDICAL ASSISTANCE PROVIDED TO A NATIVE HAWAIIAN THROUGH A FEDERALLY-QUALIFIED HEALTH CENTER OR A NATIVE HAWAIIAN HEALTH CARE SYSTEM UNDER THE MEDICAID PROGRAM.

(a) MEDICAID.—Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended, in the third sentence, by inserting '', and with respect to medical assistance provided to a Native Hawaiian (as defined in section 12 of the Native Hawaiian Health Care Improvement Act) through a Federally-qualified health center or a Native Hawaiian health care system (as so defined) whether directly, by referral, or under contract or other arrangement between a Federally-qualified health center or a Native Hawaiian health care system and another health care provider'' before the period.

(b) EFFECTIVE DATE.—The amendment made by this section applies to medical assistance provided on or after the date of enactment of this Act.

SA 1040. Mr. SCHUMER (for himself, Mr. CORZINE, Mrs. CLINTON, and Mr. LAUTENBERG) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 294, line 6, strike ''or (C)'' and insert ''(C), or (D)''.

On page 294, line 21, insert ''(other than in 2004 and 2005)'' after ''multiplied''.

On page 297, strike lines 5 through 9, and insert the following:

''(iv) For 2002 and 2003, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

''(v) For 2004 and 2005, 103 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

''(vi) For 2006 and each succeeding year, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

''(D) ANNUAL FEE-FOR-SERVICE COSTS IN 2004 AND 2005.—For 2004 and 2005, the adjusted average per capita cost for the year, as determined under section 1876(a)(4) for the Medicare+Choice payment area for items and services covered under parts A and B for individuals entitled to benefits under part A and enrolled under part B and not enrolled in a Medicare+Choice plan under this part for the year, except that such amount shall be adjusted—

''(i) to exclude costs attributable to payment adjustments described in subsection (a)(5)(B)(ii), and

''(ii) to include an amount equal to the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.

On page 298, line 10, strike ''subparagraph (B)'' and insert ''subparagraphs (B) and (E)''.

On page 301, between lines 8 and 9, insert the following:

''(E) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for 2004 and 2005, the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.

On page 302, line 23, insert ''(or, in the case of calculations for payments for months beginning on or after January 1, 2004, and before December 31, 2005, the average number of medicare beneficiaries enrolled in a Medicare+Choice plan that are)'' after ''medicare beneficiaries''.

On page 303, line 9, insert ''other than 2004 and 2005'' after ''for each year''.

On page 349, between lines 4 and 5, insert the following:

(3) PAYMENT RATES BASED ON 100 PERCENT OF FEE-FOR-SERVICE COSTS IN 2004 AND 2005.—

(A) CHANGE IN BUDGET NEUTRALITY.—Section 1853(c) (42 U.S.C. 1395w–23(c)) is amended—

(i) in paragraph (1)(A), in the flush matter following clause (ii), by inserting ''(other than in 2004 and 2005)'' after ''multiplied''; and

(ii) in paragraph (5), by inserting ''other than 2004 and 2005'' after ''for each year''.

(B) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—Section 1853(c)(3) (42 U.S.C. 1395w–23(c)(3)) is amended—

(A) in subparagraph (A), by striking ''subparagraph (B)'' and inserting ''subparagraphs (B) and (E)''; and

(B) by adding at the end the following new subparagraph:

''(E) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for 2004 and 2005, the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.''.

(C) REVISION OF NATIONAL AVERAGE USED IN CALCULATION OF BLEND.—Section 1853(c)(4)(B)(i)(II) (42 U.S.C. 1395w–23(c)(4)(B)(i)(II)) is amended by inserting ''(or, in the case of calculations for payments for months beginning on or after January 1, 2004, and before December 31, 2005, the average number of medicare beneficiaries enrolled in a Medicare+Choice plan that are)'' after ''medicare beneficiaries''.

(D) UPDATE IN MINIMUM PERCENTAGE INCREASE.—Section 1853(c)(1)(C) (42 U.S.C. 1395w–23(c)(1)(C)) is amended by striking clause (iv) and inserting the following new clauses:

''(iv) For 2002 and 2003, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

''(v) For 2004 and 2005, 103 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

''(vi) For 2006 and each succeeding year, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.''.

SA 1041. Ms. MURKOWSKI (for herself and Mr. STEVENS) submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 529, between lines 8 and 9, insert the following:

SEC. 455. FRONTIER EXTENDED STAY CLINIC DEMONSTRATION PROJECT.

(a) AUTHORITY TO CONDUCT DEMONSTRATION PROJECT.—The Secretary shall waive such provisions of the medicare program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as are necessary to conduct a demonstration project under which frontier extended stay clinics described in subsection (b) in isolated rural areas of Alaska are treated as providers of items and services under the medicare program.

(b) CLINICS DESCRIBED.—A frontier extended stay clinic is described in this subsection if the clinic—

(1) is located in a community where the closest short-term acute care hospital or critical access hospital is at least 75 miles away from the community or is inaccessible by public road; and

(2) is designed to address the needs of—

(A) seriously or critically ill or injured patients who, due to adverse weather conditions or other reasons, cannot be transferred quickly to acute care referral centers; or

(B) patients who need monitoring and observation for a limited period of time.

(c) DEFINITIONS.—In this section, the terms ''hospital'' and ''critical access hospital'' have the meanings given such terms in subsections (e) and (mm), respectively, of section 1861 of the Social Security Act (42 U.S.C. 1395x).

SA 1042. Ms. MURKOWSKI (for herself and Mr. STEVENS) submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle B of title IV, add the following:

SEC. ___. TREATMENT OF PHYSICIANS' SERVICES FURNISHED IN ALASKA.

Section 1848(b) (42 U.S.C. 1395w–4(b)) is amended—

(1) in paragraph (1), in the matter preceding subparagraph (A), by striking ''paragraph (2)'' and inserting ''paragraphs (2) and (4)''; and

(2) by adding at the end the following new paragraph:

''(4) TREATMENT OF PHYSICIANS' SERVICES FURNISHED IN ALASKA.—

''(A) IN GENERAL.—With respect to physicians' services furnished in Alaska on or after January 1, 2004, and before January 1, 2014, the fee schedule for such services shall be determined as follows:

''(i) Subject to clause (ii), the payment amount for a service furnished in a year shall be an amount equal to—

''(I) in the case of services furnished in calendar year 2004, 90 percent of the VA Alaska fee schedule amount for the service for fiscal year 2001; and

''(II) in the case of services furnished in each of calendar years 2005 through 2013, the amount determined under this clause for the previous year, increased by the annual update determined under subsection (d) for the year involved.

''(ii) In the case of a service for which there was no VA Alaska fee schedule amount for fiscal year 2001, the payment amount shall be an amount equal to the sum of—

''(I) the amount of payment for the service that would otherwise apply under this section; plus

''(II) an amount equal to the applicable percent (as described in subparagraph (C)) of the amount described in subclause (I).

''(B) VA ALASKA FEE SCHEDULE AMOUNT.—For purposes of this paragraph, the term 'VA Alaska fee schedule amount' means the amount that was paid by the Department of Veterans Affairs in Alaska in fiscal year 2001 for non-Department of Veterans Affairs physicians' services associated with either outpatient or inpatient care provided to individuals eligible for hospital care or medical

services under chapter 17 of title 38, United States Code, at a non-Department facility (as that term is defined in section 1701(4) of such title 38.

''(C) APPLICABLE PERCENT.—For purposes of this paragraph, the term 'applicable percent' means the weighted average percentage (based on claims under this section) by which the fiscal year 2001 VA Alaska fee schedule amount for physicians' services exceeded the amount of payment for such services under this section that applied in Alaska in 2001.''.

SA 1043. Mr. ALLARD submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 377, between lines 12 and 13, insert the following:

''(I) Section 1851(d) (relating to the provision of information to promote informed choice).

''(J) Section 1851(h) (relating to the approval of marketing material and application forms).

''(K) Section 1852(e)(4) (relating to treatment of accreditation).

''(L) Section 1857(i) (relating to Medicare+Choice program compatibility with employer or union group health plans).''.

NOTICES OF HEARINGS/MEETINGS

COMMITTEE ON AGRICULTURE, NUTRITION, AND FORESTRY

Mr. COCHRAN. Mr. President, I announce that the Committee on Agriculture, Nutrition, and Forestry will conduct a hearing on June 26, 2003 in SR–328A at 9 a.m. The purpose of this meeting will be to review H.R. 1904, The Healthy Forests Restoration Act of 2003.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIRS

Mr. SUNUNU. Mr. President, I ask unanimous consent that the Committee on Banking, Housing, and Urban Affairs be authorized to meet during the session of the Senate on June 24, 2003, at 10 a.m. to conduct a hearing on ''Bus Rapid Transit and Other Bus Service Innovations.''

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

Mr. SUNUNU. Mr. President, I ask unanimous consent that the Committee on Commerce, Science, and Transportation be authorized to meet on Tuesday, June 24, 2003, at 9:30 a.m. on Reform of the USOC.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. SUNUNU. Mr. President, I ask unanimous consent that the Committee on Energy and Natural Resources be authorized to meet during the session of the Senate on Tuesday, June 24 at 10 a.m. in room SD–366. The purpose of this oversight hearing is to receive testimony on issues associated with changes in the relationship between the U.S. Department of Energy and the contractors operating its National Laboratories, other laboratories and sites.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON FOREIGN RELATIONS

Mr. SUNUNU. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on Tuesday, June 24, 2003 at 2:30 p.m. to hold a hearing on U.S. Relations With A Changing Europe: Differing Views on Technology Issues.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON GOVERNMENTAL AFFAIRS

Mr. SUNUNU. Mr. President, I ask unanimous consent that the Committee on Governmental Affairs be authorized to meet on Tuesday, June 24, 2003, at 10 a.m. for a hearing entitled ''Controlling the Costs of Federal Health Programs by Curing Diabetes: A Case Study.''

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON THE JUDICIARY

Mr. SUNUNU. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet to conduct a markup on Tuesday, June 24, 2003, at 9:30 a.m. in SDG 50.

Agenda

1. Indexing All Awards for Future Inflation: This amendment indexes claim award values to inflation.

2. Removing Collateral Source Offsets: This amendment ensures that more money will go to claimants by striking all existing collateral source offsets in the bill except for compensation from past settlements and judgments for the same asbestos-related injury.

3. Doubling the Statute of Limitations: This amendment doubles the statute of limitations from 2 to 4 years to allow more claimants access to the fund and to help alleviate the potential backlog of claims at the beginning of the Fund's creation.

4. Coverage for Claimant Exposures on U.S. Flag Ships or While Working for U.S. Companies Abroad: This amendment broadens eligibility to include claims made by U.S. citizens exposed to asbestos while serving on any U.S. flagged or owned ship or exposed to asbestos while working for U.S. companies overseas.

5. Strengthening Enforcement of Contributions: This amendment strengthens the Administrator's cause of action to enforce contributions by permitting the assessment of punitive damages for willful failure to pay.

6. Recoupment Authority for the Administrator: This amendment protects the funds available to pay claimants by permitting the Administrator to recover any financial hardship or inequity adjustment in future years if a company later becomes financially capable of paying its full allocation into the fund.

7. Criminal Penalties for Fraud or False Information: This amendment protects the integrity of the claims administration process by imposing criminal penalties for fraud and false statements made against the Fund.

8. Bankruptcy Certification: Requires the bankruptcy court to certify whether or not asbestos liabilities were the cause of the bankruptcy.

9. Congressional Oversight—Administrator Annual Reports: This amendment provides appropriate Congressional oversight by requiring the Administrator of the Asbestos Fund to submit an annual report on the functioning of the Fund to Congress.

Technical Amendments

10. Hatch Technical Amendment: Technical amendments to S. 1125.

Other Agreed Upon Amendments

11. Hatch Libby Amendment: Senator BAUCUS has agreed to this Amendment, which ensures that claimants from Libby, Montana will be compensated from this Fund and that their claims will be evaluated by the exceptions panel due to the unique nature of the asbestos there.

12. Hatch Asbestos Ban: This amendment prohibits the manufacture, distribution and importation of the consumer products to which asbestos is deliberately or knowingly added. The amendment also contains specific exemptions and authorizes the Administrator to hear and grant exemptions on a case by case basis.

13. Feinstein Second Degree to Hatch Asbestos Ban: This amendment adds certification requirements for the Government Use exemption, and authorizes the Administrator of the EPA to review the exemption for roofing cements and related products.

Medical Criteria Amendments

14. Hatch Medical Exceptions Panel Amendment: This panel will review claims which do not fit the criteria but may have an exceptional case to merit payment. Libby claims will automatically go through this panel.

15. Hatch Striking Product ID Amendment: (Leahy co-sponsor)—Drops requirements to identify particular asbestos product.

16. Hatch Latency Period Amendment: (Leahy co-sponsor)—Clarifies the 10-year latency period for all claims.

17. Hatch Medical Monitoring Amendment: Requires the administrator to notify qualifying claimants about medical monitoring options.

18. Hatch Doctor Evaluation Amendment: Requires physician to evaluate smoking and exposure history before making a diagnosis.

19. Hatch Deceased Claimant Amendment: Eliminates in-person examination requirement for persons who have died prior to filing their claim.

20. Hatch Disease Categories and Standards Amendment: (Sec. 124)—Replaces the previous criteria with a new level for severe asbestosis (V); a mixed-causation level (II); three levels of lung cancer payments; substantial occupational exposure measured in ''weighted'' years.

21. Hatch Independent Review Amendment: This allows the Asbestos Court to conduct its own reviews of medical evidence to ensure quality control.

22. Hatch Smoking Assessment Amendment: Allows the Asbestos Court to make a limited investigation into a claimant's smoking history to determine veracity.

23. Hatch Treating Doctor Amendment: Requires that a doctor making a diagnosis be the ''claimant's doctor,'' as opposed to ''treating'' doctor.

24. Hatch IOM Study Amendment: Directs the Institute of Medicine to study the link between asbestos and ''other cancers.''

25. Hatch Weighted Exposure Amendment: For substantial occupational exposure requirement, the weighted exposure gives more credit for exposure in earlier years, or in certain occupations, than exposure in more recent, post-regulation years.

26. Hatch Take Home Exposure Amendment: Amendment clarifies that claimants exposed to asbestos by cohabitants who brought home asbestos on their clothes from their jobs will meet the exposure requirement in the bill.

27. Kyl Significant Amount Amendment: This amendment amends section 124(a)(8)(B) and (C) of S. 1125 to require ''significant amounts'' of exposure to qualify for having ''significant occupational exposure.''

28. Kyl Significant Amount Amendment: This amendment amends section 124(a)(16)(B) and (C) of amended medical criteria to require ''significant amounts'' of exposure to qualify for having ''significant occupational exposure.''

29. Kyl Lock Box Amendment: Inserts a new section 223(e) into the introduced bill that requires a ''lock box'' mesothelioma account used solely to make payments for claimants at Levels IV, VII, and VIII.

30. Kyl Lock Box Amendment: Inserts a new section 223(e) into S. 1125 as amended with new Hatch criteria that requires a ''lock box'' mesothelioma account used solely to make payments for claimants at Level IX, Lung Cancer II, Severe Asbestos II and Severe Asbestos I.

31. Leahy Colorectal Cancer Amendment: Adds colorectal cancers as compensable cancers in the fund.

32. Leahy Take Home Exposure Amendment: A claimant meets the medical requirements if they can show exposure to asbestos was result of living with a person who was occupationally defined.

33. Kennedy Medical Advisory Committee/Exceptional Medical Claim Amendment: Adds to section 114 to grant the chief judge the authority to appoint a Medical Advisory Committee of doctors with certain qualifications. Also creates, in section 124, a process for a claimant to submit an application for an ''exceptional medical claim'' that does not fall within the medical criteria parameters within the bill.

34. Kennedy Awards Amendment: Amends the awards allowed by increasing the amounts for: (1) Lung Cancer I to ''individual determination''; (2) Lung Cancer II to $500,000 or $1,500,000; (3) Mesothelioma to $1,500,000; (4) Increases amounts non-smokers receive by lots of money.

35. Kohl Mesothelioma Amendment: Increases the mesothelioma compensation award from $750,000 to $1,500,000.

36. Feingold Medical Monitoring Amendment: Establishes a medical monitoring system within 180 days of the Act's implementation. Creates criteria required to obtain medical monitoring and the protocols used for medical screening. Screening shall occur within 5 years. The administrator will promulgate procedures and regulations establishing medical monitoring program.

Other Amendments

37. Hatch Back-End Amendment: Provides defendant contributors the option to continue paying into the fund after year 27 or be subject to a civil claim filed in federal court.

38. Hatch Silica Mixed Dust Amendment: This amendment clarifies that asbestos related mixed dust claims are covered by the bill.

39. Grassley Asbestos Court Amendment: Eliminates the Court of Asbestos claims, instead housing the tribunal in the Federal Court of Claims. The Chief Judge may appoint up to 20 special asbestos masters without Congressional approval. A special master will make the determination, appealed to the Court of Claims and the Federal Circuit.

40. Grassley Federal Liability Amendment: Amendment provides that nothing in the act establishes liability against the Federal Government nor should it be construed to obligate funding from the United States government.

41. Leahy Environmental Crimes Amendment: Amendment enhances the penalties for environmental crimes by expanding the available crimes covered involving asbestos and applies the provision retroactively and requires the person who discovers the crime report to the proper State law enforcement authorities within 30 days.

42. Sessions Cap on Attorneys' Fee Amendment: Amendment imposes a 10 percent cap on attorneys fees.

43. Sessions Pro Bono Amendment: Amendment requires the Asbestos Court to provide information to claimants of pro bono representation. Attorneys must provide notice of pro bono representation.

44. Sessions Substitute Amendment: Amendment substitutes S. 1125 with language from Senator Nickles alternative tort reform proposal.

45. Leahy FOIA Amendment for the Commission: Amendment extends the Freedom of Information Act to apply to the Asbestos Insurance Commission.

46. Leahy FOIA Amendment for the Office of Asbestos Injury Claims Resolution: Amendment extends the Freedom of Information Act to apply to the Office of Asbestos Injury Claims Resolution.

47. Leahy Successor in Interest Amendment: Requires that a business that changes its formal structure, yet ''substantially continues'' to maintain the same function, will remain obligated to fund the Trust.

48. Kennedy Purpose of S. 1125 Amendment: Amendment specifies that the purpose of S. 1125 should be expeditious compensation to individuals exposed to asbestos, provide compensation based on a system ''flexible enough to accommodate individuals whose conditions worsen'', to establish a trust fund to create certainty and predictability, and relieve federal and state courts of asbestos litigation burdens.

49. Kohl Contingent Call and Fund Certification Amendment: Amendment permits the Administrator to assess additional contributions during the first 27 years of the fund and/or decline any scheduled allocation reductions unless the Administrator certifies. Amendment also requires the Administrator, prior to reducing defendant allocations, to certify that the fund will have sufficient money to compensate past, present and future claimants, for various segments during the life of the fund, including a procedure for making the determination.

50. Feinstein Occupational Related Disease Study Amendment: Amendment requires any excess funds from the Trust to be directed to NIH for the study of occupational-related diseases.

51. Feinstein Date of Occupational Exposure Amendment: This amendment strikes the December 31, 1982 cutoff dates for occupational exposures.

52. Feinstein Back End Proposal: Requires mandatory payments to continue after year 27 at year 26 levels if the Administrator deems it necessary to ensure adequate funding of the Fund. The Administrator will provide a report to Congress if additional future funds are necessary.

53. Feinstein Asbestos Ban Amendment: Adds Title V to ban the use of asbestos in commercial products. Provides for exceptions with a list of products and provides for civil penalties. Amends title 18 U.S.C. to add chapter 34 enumerating an asbestos related crime. Provides money for research into asbestos-causing diseases, a mesothelioma registry and establishes Mesothelioma research and treatment

centers. The amendment is superfluous after Senators Hatch, Feinstein, Kohl and Murray agreed to the Hatch Asbestos ban Amendment.

54. Feingold Sunset Amendment: Provides a check on liability that (c) and (d) has no effect on January 1, 2010 unless the Administrator certifies prior to that date that 95 percent of all compensable claims file on or before May 1, 2006 have been paid in full.

55. Feingold Payments Amendment: Amendment changes the word ''less'' to ''more'' on page 40 line 4 so that all payments will be made within 3 years.

56. Durbin Lawsuit Filing Date Amendment: Amendment does not require any lawsuit filed before June 1, 2003 to be dismissed prior to adjudication.

57. Durbin Prior Asbestos Expenditure Amendment: Amends the term ''prior asbestos expenditure'' to exclude defense costs mounted in a successful defense against an asbestos claim.

58. Durbin FELA Amendment: Amendment removes the FAIR Act's preemption of FELA claims for asbestos injuries.

59. Durbin Hardship Amendment: Doubles the current caps for the financial hardship and inequity adjustments while revising the definition of ''inequity adjustments'' to include costs incurred in cases where the defendant mounted a successful defense.

60. Hatch Congressional Findings.

61. Leahy Congressional Findings.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON RULES AND ADMINISTRATION

Mr. SUNUNU. Mr. President, I ask unanimous consent that the Committee on Rules and Administration be authorized to meet during the session of the Senate on Tuesday, June 24, 2003, at 9:30 a.m., to consider the markup of pending legislative and administrative business, including any other items that may be ready for consideration.

The PRESIDING OFFICER. Without objection, it is so ordered.

SUBCOMMITTEE ON CHILDREN AND FAMILIES
SUBCOMMITTEE ON PERSONNEL

Mr. SUNUNU. Mr. President, I ask unanimous consent that the Committee on Health, Education, Labor, and Pensions, Subcommittee on Children and Families, and Committee on Armed Services, Subcommittee on Personnel be authorized to meet for a hearing on Supporting Our Military Families during the session of the Senate on Tuesday, June 24, 2003, at 2:30 p.m.

The PRESIDING OFFICER. Without objection, it is so ordered.

SUBCOMMITTEE ON FISHERIES, WILDLIFE, AND WATER

Mr. SUNUNU. Mr. President, I ask unanimous consent that the Subcommittee on Fisheries, Wildlife, and Water be authorized to meet on Tuesday, June 24 at 9:30 a.m. to examine implementation of the National Marine Fisheries Service's 2000 Biological Opinion for listed anadromous fish regarding operation of the Federal Columbia River Power System.

The hearing will take place in SD 406, Hearing Room.

The PRESIDING OFFICER. Without objection, it is so ordered.

SUBCOMMITTEE ON PERSONNEL

Mr. SUNUNU. Mr. President, I ask unanimous consent that the Subcommittee on Personnel of the Committee on Armed Services be authorized to meet during the session of the Senate on Tuesday, June 24, 2003, at 2:30 p.m., in open session to continue to receive testimony on issues affecting families of soldiers, sailors, airmen and marines.

The PRESIDING OFFICER. Without objection, it is so ordered.

PRIVILEGES OF THE FLOOR

Mr. DODD. Mr. President, I ask unanimous consent that Meghan Taira, a fellow on Senator DASCHLE's staff, be granted floor privileges during the consideration of S. 1.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mrs. CLINTON. Mr. President, I ask unanimous consent that Dr. Leonardo Trasande and Dr. Murali Raju, legislative fellows in my office, be granted floor privileges for the duration of this debate.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. Mr. President, I ask unanimous consent that Jessica Donze and Michelle Curtis, two fellows in Senator BINGAMAN's office, be granted the privilege of the floor during the pendency of the debate on S. 1.

The PRESIDING OFFICER. Without objection, it is so ordered.

MEASURE READ THE FIRST TIME—S. 1323

Mr. FRIST. I understand that S. 1323 is at the desk and I ask for its first reading.

The PRESIDING OFFICER. The clerk will read the bill by title.

The legislative clerk read as follows:

A bill (S. 1323) to extend the period for which chapter 12 of title 11, United States Code, is reenacted by 6 months.

Mr. FRIST. I now ask for its second reading and object to further proceeding on this matter.

The PRESIDING OFFICER. Objection having been heard, the bill will receive its second reading on the next legislative day.

ORDERS FOR WEDNESDAY, JUNE 25, 2003

Mr. FRIST. Mr. President, I ask unanimous consent that when the Senate completes its business today, it stand in adjournment until 9:30 a.m., Wednesday, June 25. I further ask that following the prayer and pledge, the morning hour be deemed expired, the Journal of proceedings be approved to date, the time for the two leaders be reserved for their use later in the day, and the Senate then resume consideration of S. 1, the prescription drug benefits bill.

The PRESIDING OFFICER. Without objection, it is so ordered.

PROGRAM

Mr. FRIST. Mr. President, today we made great progress toward finishing the prescription drug/Medicare reform legislation. We debated many amendments. We had nine rollcall votes in relation to the pending amendments during today's consideration of this bill.

Tomorrow morning, we will resume consideration of S. 1. I would anticipate another busy day on this bill as well tomorrow. On Wednesday, the first rollcall vote was anticipated to be at 10 a.m. However, at this time the final legislative draft is not ready. We will continue to work on that draft over the course of the evening and into the morning, but at this juncture I will likely have to notify our Members as early as possible tomorrow morning as to whether we will actually call that rollcall vote at 10 a.m. I am hopeful that we can. If the legislative language is not ready, we will not have that vote at 10 a.m., but I hope to be able to announce that at 9:30 in the morning.

I do want to remind my colleagues that at this juncture we have approximately 42 amendments still pending to the bill. These amendments will have to be addressed by the Senate in some fashion, although I am very hopeful that many of these amendments can be disposed of without a rollcall vote. In any event, we have a lot of work to do before we have passage of this bill.

I, once again, will state that it is my intention that we will finish consideration of the prescription drug/Medicare reform bill prior to the July 4 recess—many hours, a lot of hard work, but we are on course to accomplish that, and I expect that we will do so.

I look forward to another productive day tomorrow as we begin the final consideration of this bill.

ADJOURNMENT UNTIL 9:30 A.M. TOMORROW

Mr. FRIST. If there is no further business to come before the Senate, I ask unanimous consent that the Senate stand in adjournment under the previous order.

There being no objection, the Senate, at 9:13 p.m., adjourned until Wednesday, June 25, 2003, at 9:30 a.m.